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USE OF MEDICARE PAYMENT METHODOLOGIES AND COST CONTAINMENT STRATEGIES BY MEDICAID PROGRAMS AND PRIVATE PAYERS

Final Report

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EXECUTIVE SUMMARY

The primary purpose of this study was to evaluate the extent to which the Resource Based Relative Value Scale (RBRVS) and physician payment policies accompanying the Medicare Fee Schedule (MFS) are viable options for other public and private payers. Two research methods were utilized. The first involved analysis of survey data on 333 payers across eight categories collected by the Boston office of Deloitte & Touche on the diffusion of RBRVS. The survey included over 50 questions about the methods payers use to compensate physicians for their services. The second research method used was in-depth case studies of a dozen payers--six public and six private--that are adopting or actively considering an RBRVS-based system. The case studies were used as a vehicle for acquiring detailed, qualitative information about the process used to develop an RBRVS-based payment system. This information complemented the broader, more quantitative data obtained from the survey. In general, the two methods provided consistent information which led to the conclusions below.

What are the overall trends in the adoption of RBRVS?

- Payers most likely to adopt RBRVS are Blue Cross/Blue Shield plans, IPA-model HMOs and PPOs.
- 19 of 24 Blue Cross/Blue Shield plans responding to the survey have adopted RBRVS.
- 15 of 48 Medicaid progams have adopted RBRVS; another 11 are actively considering adoption.
- Penetration is greatest in managed care products, accounting for 75% of all affected insurance products.
- RBRVS is least likely to be applied to traditional indemnity products.
- Payers with a concentration of business in the Midwest and West regions are more likely to adopt RBRVS.
- RBRVS adopters tend to have larger enrollee size and higher total physician expenditures than payers not adopting RBRVS.

What are the goals and expectations of payers adopting RBRVS?

- Increase fees for primary care services, especially for Medicaid programs and PPOs.
- Redistribute payments to primary care providers to improve beneficiary access to care.
- Control growth in physician service costs.
- Reduce administrative expenses.

What are payers' perceptions regarding the RBRVS concept and concerns over its potential use?

- The basic underlying concept is widely accepted by both private and public payers as being sound.
- RBRVS is perceived as a tool to rationalize physician payment.
- Payers are especially concerned about negative impacts on physician relations.
- Payers have concerns over potential costs to convert to RBRVS.
- Newness of RBRVS and uncertainty surrounding national health care reform are major concerns to payers.

What particular modifications to HCFA RVUs were made?

- One-third of adopters modified RVUs in at least one area of medicine: pediatrics, OB/GYN, pathology, radiology, surgery, emergency medicine, neurology, and rehabilitation.
- Blue Cross/Blue Shield plans modified OB/GYN RVUs most often among all areas.
- Medicaid programs modified RVUs for pediatric codes more than any other area of medicine.
- Modifications to RVUs by managed care organizations were most prevalent in OB/GYN and pediatric codes.
- A significant number of respondents are uncertain about modifying RVUs.

To what extent are Medicare payment policies being adopted or modified?

- Payers revealed tremendous uncertainty over payment policies.

- Surgery payment policies similar to Medicare's are the most likely to be implemented along with RBRVS.

- Site-of-Service differentials, nonpayment for EKG interpretations, new provider differentials, and volume performance standards were largely rejected by most payers.

- Payment for nonphysician providers were highly variable across payers.

- Where used, geographic fee adjustments were made by adjusting conversion factors or using statewide GPCIs.

- Payers with existing physician participation agreements were more likely to adopt RBRVS.

- Concern over balance billing limitations is a major impediment to adopting RBRVS for many payers.

How are RBRVS and MFS elements being incorporated into payers' cost containment strategies?

- 40% of adopters expect RBRVS to contain costs, but only 5% use volume performance standards.

- Some payers expect to contain costs through RBRVS by limiting cost shifting from other payers.

- Some payers intend to use RBRVS to improve physician profiling to limit increases in utilization and intensity of services.

The potential for RBRVS to be used for broader physician payment reform is significant, as evidenced by the adoption rates found in this study. Widespread use of the other two major components of the MFS--MVPS and payment policies--seems remote, however. Many payers view RBRVS as a viable, and in some cases a very necessary, option. The underlying relative value principles of RBRVS are widely accepted among private and public payers. Moreover, in developing RBRVS fee schedules, payers have generally gone forward with the technical aspects first, leaving payment policies, billing guidelines, and update protocols to be decided upon later. This is, perhaps, a reflection of the great uncertainty by payers to adopt Medicare policies or modify their existing ones, the newness of RBRVS, and uncertainty over the outcome of national health care reform. Finally, many payers now adopting RBRVS expect to achieve cost containment, but through means other than MVPS.

1.0 BACKGROUND AND PURPOSE

On January 1, 1992, Medicare began to phase in the new Medicare Fee Schedule (MFS) for physician services based on the Resource Based Relative Value Scale (RBRVS) developed by the Harvard University research team led by Dr. William Hsiao (Hsiao *et al*, 1988). Origins of the MFS date back to 1989 when Congress passed the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). The three primary goals of OBRA-89 were: 1) to create an equitable payment system for physician services; 2) to contain the growth in the physician component of health care costs; and 3) to protect beneficiaries from increased liability.

The Medicare Fee Schedule (MFS) was intended primarily to accomplish the first goal. Under the MFS, physician payments would be based on relative value units (RVUs) to represent the work time and intensity of providing physician services. Accompanying the MFS are mechanisms called Medicare Volume Performance Standards (MVPS) designed to set physician payments updates according to physician expenditure growth targets. As such, the MVPS is aimed at controlling costs by discouraging or mitigating the growth in the volume of patient care. Protecting Medicare beneficiaries from increased liability is a concern from both equity and cost perspectives, and is addressed by Medicare through limitations on balance billing by providers.

Under the MFS, physician payments are derived by the following formula:

$$Payment_i = CF * (RVU_{i,wk} * GAF_{wk,L} + RVU_{i,pe} * GAF_{pe,L} + RVU_{i,mp} * GAF_{mp,L})$$

where i is the ith service or procedure GAFs are geographic adjustment factors, and CF is the conversion factor to convert the sum of the three RVU-GAF products. The three RVU and GAF components are indicated with subscripts: subscript wk indicates physician work involved in performing service i, subscript pe represents practice costs associated with service i, and mp represents physician malpractice expense. RVUs vary by procedure while GAFs only vary by Medicare payment locality L.

Historically, Medicare has been the health care industry leader in terms of reimbursement policy, setting standards for other payers to follow. It may be the case that other payers share some of the same goals as Medicare (e.g., rationalizing physician payments; raising fees for primary care services) or simply want to maintain compatability with Medicare. Medicaid programs, for instance, may view RBRVS as an effective method to ensure access to care for their beneficiaries by improving relative fees for primary care services. Another reason payers might be studying RBRVS is to assess its feasibility as a cost containment technique. Rising physician service costs are not exclusive to the Medicare program: Total national per capita expenditures on physician's services increased from $178 in 1980 to $458 in 1989, while the percent of private insurance payments toward physicians' services has increased from 61.5% in 1980 to 71.5% in 1989 (U. S. Dept of Commerce). RBRVS is not a cost-containment method per se since it preserves the practice of fee-for-service medicine. However, some payers may view it as crucial in containing costs by limiting "cost-shifting" from other payers or by providing a tool to compare physician output profiles to better manage volume or intensity of care.

Apart from RBRVS are Medicare's payment policies. This distinction may or may not be apparent to many payers. In studying the MFS, some payers may be considering specific payment policies while rejecting others outright. For instance, Medicare's balance billing limitations may not be viable for some types of private payers. Medicare's cost control mechanism--the MVPS--may be infeasible for many payers for political reasons. *A priori*, it seems reasonable to expect payers to "pick and choose" specific policies from the Medicare payment policy menu. Knowledge about the background characteristics of payers' payment systems is necessary for understanding why various payment policies are adopted or why modifications are made to policy rules.

The primary purpose of this study is to gather a variety of information about the adoption of the RBRVS methodology and Medicare payment policy components by private payers and other public, non-Medicare payers in order to examine the following questions:

- What are the trends in the adoption of RBRVS?
- How do the trends vary by type of payer?
- What were payers' goals, expectations and perceptions regarding RBRVS?
- How were payers' fee schedules developed?
- What particular modifications to HCFA RVUs and payment policies were made?
- How are RBRVS and MFS elements being incorporated into payers' cost containment strategies?

Before addressing these questions, we must first attempt to understand the reasons non-Medicare payers are considering RBRVS at all. What do private payers or other public payers see as beneficial or detrimental in the RBRVS? What factors are motivating payers' examination and adoption or rejection of RBRVS? Do non-Medicare payers view RBRVS as being synonymous with the Medicare fee schedule? And, do payers think RBRVS will help control expenditures?

In this report, we summarize the findings from a large RBRVS survey and case studies of non-Medicare payers, examine observable patterns in the diffusion of RBRVS, assess the methodological contributions to physician service payment from specific payers, and assess the potential of RBRVS in reshaping the overall physician payment system. A key concept maintained throughout this report is the distinction of the RBRVS from the MFS. The synthesized information compiled in this report provides HCFA with a snapshot of the RBRVS developments among other payers and is a timely, convenient reference tool for policy makers now debating national health care reform.

The remainder of the report is organized as follows. In Section 2.0 we discuss the Deloitte & Touche RBRVS survey, our collaboration with Deloitte & Touche, and the HER case studies of various third-party payers. Section 3.0 shows the major findings from the Deloitte & Touche survey regarding RBRVS and payment policy rules and billing practice guidelines. We include individual, comprehensive, in-depth case study reports in Section 4.0. A synthesis of

the results from the survey and case studies and a discussion of the policy implications from the diffusion of the RBRVS methodology are found in Section 5.0.

2.0 DATA AND METHODS

Section 2.1 reviews the first component of this project which involved a survey of public and private payers of physician services regarding an RBRVS-based payment system. Survey recipients were provided with a brief background of Medicare's implementation of the Resource Based Relative Value Scale (RBRVS) payment system. They were told that Medicare's adoption of RBRVS represented one of the most significant physician payment reforms in decades and that other payers are considering following Medicare's lead. They were also informed that this survey was the first in a new series of surveys which will track emerging trends in physician payment policies and practices. Respondents were promised confidentiality, thus findings for private payers are reported in aggregate only. Specific payers are not identified.[1]

Section 2.2 discusses the second component of the project which involved one dozen case studies with payers that have implemented or are considering implementation of an RBRVS-based payment system. The methodology used and the data collected for this component of the project are reviewed.

2.1 Payer Survey

During the summer of 1993, the Boston office of Deloitte & Touche, an international accounting and consulting firm, sent a mail survey to nearly 2,000 different payer organizations. The survey included over 50 questions about the methods payers use to compensate physicians for their services. Respondents were asked to either mail or fax their comments to the Management Consulting Division of Deloitte & Touche (D & T).

The sampling frame is comprised of Deloitte & Touche's survey database of 1,923 payers which includes traditional indemnity insurers, managed care organizations, Blue Cross & Blue Shield organizations, third-party administrators, self-insured employers and state Medicaid programs. Their database was developed using Charles Singer & Company's databases of private payers in the U.S.[2] Added to the Singer collection by Deloitte & Touche were Fortune 500 self-insured corporations and Medicaid programs in all states and jurisdictions. In some instances, two or three contacts were available in each of the state

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[1] Health Economics Research (HER) and Deloitte and Touche (D & T) agreed to share use of the data as part of an overall research and publication effort under the agreement that all individual identifiers were removed from the data and findings were reported in aggregate.

[2] See appendix for further information on the database.

Medicaid programs. This 'overlap' technique is used to increase response rates and to address the decentralization of responsibilities in state Medicaid programs.

The final sample includes 333 payers and represents a wide spectrum of organizational diversity. The number of payers in the each category of the sampling frame and number of actual respondents are shown in Exhibit 1. Ten payers could not be classified solely in any of the payer categories, thus they are coded as "other." An example of a payer in this group is an Exclusive Provider Organization (EPO).[3]

Exhibit 1 Payer Organizations in the Deloitte & Touche Survey

Payers	Sampling frame	Respondents
State Medicaid Programs	51	32
Indemnity Insurers	131	27
Blue Cross/Blue Shields	64	24
Health Maintenance Organizations		
IPA Model*	283	87
Staff/Group Model	323	10
Preferred Provider Organizations	377	51
Third-party Administrators	423	68
Self-insured Corporations	271	24
Other	--	10
Total	N = 1,923	N = 333

*Some responses for IPA-model HMOs were provided by Independent Physicians Associations which provide administrative services to IPAs.

The response rate varied within payer categories, but overall it was approximately 20 percent. Deloitte & Touche indicated that this response rate is near their industry's average. It is also important to note that the data collection timeline did not allow for systematic follow-up (such as additional mailings or using incentives to increase participation) which is a recommended approach to improving response rates, especially in mail surveys (Dillman, 1978).

[3]An Exclusive Provider Organization (EPO) is a more rigid type of PPO, closely related to an HMO, that requires individuals to use only designated providers or sacrifice reimbursement altogether.

2.1.1 Survey Generalizability

A major purpose of HER's research project was to identify payers who use, or are planning to use, the Medicare Fee Schedule (MFS) or variants of the MFS, and to determine the specifics of the various systems in different environments. A handful of smaller, less formal surveys of RBRVS diffusion have been conducted, either by government agencies or private associations. To our knowledge, none has collected as much information in terms of depth or sample size as the D & T Survey. Unfortunately, D & T's sample was not randomly selected, although the universe was almost selected for some payer categories (e.g., Medicaid, indemnity insurers). Therefore, it is not appropriate to extrapolate survey results to national averages through the use of statistical weights.

We were concerned about the potential sample bias for mainly one reason: the actual percent of payers adopting RBRVS may be overstated if payers more interested or involved in the subject matter comprise a larger part of the respondents. To test for such a bias, Deloitte & Touche conducted a follow-up survey of the non-respondents. Payer groups contacted during the follow-up survey include indemnity insurers, PPOs, and state Medicaid programs. Through the combined efforts of the original and follow-up surveys, nearly the universe of Medicaid programs was contacted.

The purpose of the follow-up survey was to provide information about the representativeness of respondents in the original sample. Comparisons of the percent of RBRVS adopters were made in addition to comparisons of both sample's descriptive characteristics. The research team also retrospectively calculated sample sizes within each payer category that would be necessary to obtain robust results. Through these efforts, we were reassured that the diffusion of RBRVS in our sample is quite representative. (See Appendix for further explanation and Exhibits.)

2.1.2 Topics Covered

In order to determine the diffusion of RBRVS beyond Medicare, other private and public payers were asked several questions about the extent to which their organization has embraced the system. To create a basis for classification during the comparative analysis, payers were first queried about general descriptive information. Specifically, they were asked to supply information on their specific type of organization, the product lines offered, geographical coverage area, and organizational size.

Payer Categories

At the outset of the survey, each payer self-classified their organization. They were offered eight payer categories from which to choose -- traditional indemnity insurer, IPA-model HMO, Staff/Group-model HMO, Preferred Provider Organization (PPO), Blue/Cross & Blue Shield (BC/BS), third-party administrator (TPA) , self-insured employer or state Medicaid program. Although this data was already available and was used in developing the sampling frame, payers were asked to self-classify in case their status had changed.

Product Lines

Payers often offer a mix of product lines, ranging from indemnity to managed care products for the under and over 65 populations. It was important for the purpose of estimating the true diffusion of RBRVS to be cognizant of all product lines offered by a payer and to specifically ask about which of their products RBRVS is being applied or considered. It would be incorrect to assume that all of a payer's products would be converted to RBRVS, particularly for payers with diverse products. Considering the volatile climate in the health care industry, we anticipated that many payers would "try out" RBRVS on one or two product lines first before making a complete transition. It is also likely that payers may apply RBRVS to only a percentage of their physicians or enrollees, therefore, inquiries were made regarding this possibility.

Respondents were provided with the following choices to describe their products lines. (They were asked to indicate multiple product lines if it was applicable. Later in the survey, respondents were offered these choices again regarding the application of RBRVS.)

- Traditional Indemnity;
- Managed Indemnity;
- HMO;
- PPO;
- Point of Service; and
- Other.

Geographical Coverage Areas

A question was posed regarding the region(s) in which their products were available in order to determine if certain areas are more amenable to RBRVS. Most often, a payer provides services in a single area of the country, although the area may be the entire state. However, some payers, especially large indemnity insurers, provide their services through separate physician networks located across the country. These payers were classified as "nationwide" because of their national

presence in the insurance market. All other payers were grouped into one of the four traditional regional categories used in the Statistical Abstract series.

Organizational Size

Statistical and financial information on the number of physicians and enrollees in their plan and the organization's total payments for physician services in 1992 was also retrieved. This data was used as a proxy to estimate the net impact of decisions made by the groups, with the larger payers having a greater impact on the market and the smaller having less impact. We expected substantial variation to exist across payer categories. Payers were also asked to indicate how their expenditures on physician services in 1992 compared to previous years, hypothesizing that payers realizing significant expenditure growth would be dissatisfied with their current system and perhaps more likely to implement a change.

Reasons for Adopting or Not Adopting RBRVS

Part of our research effort was to determine the factors that motivate payers to change from their current payment system to RBRVS. All payers were asked to indicate their perceptions of the benefits and drawbacks of using a payment system based on Medicare's RBRVS, regardless of whether or not they were adopting RBRVS. Survey respondents ranked the importance level (high, moderate, and low) of some commonly cited benefits. Those included in our study are:

- Rationalizing physician payments;
- Rewarding primary care physicians;
- Controlling health care costs;
- Avoiding cost-shifting;
- Making their system compatible with Medicare; and
- Responding to competition.

Understanding the factors that prompt payers to adopt RBRVS provides insight about future diffusion of this payment system.

Payers repeated this ranking exercise regarding the following potential drawbacks/problems of RBRVS:

- Disruption of physician relations;
- Newness of the system;
- High conversion costs;
- Complications of the system;
- Lack of sufficient expertise; and
- Disagreement with methodology.

Adoption of an RBRVS-based payment system

What was viewed as the pivotal question in the survey was the extent to which a payer's organization has embraced an RBRVS-based payment system. Based on the answer to this question, respondents were either skipped out of the remainder of the survey or were asked to continue with additional questions. Specifically, payers were asked:

"To what extent has your organization embraced an RBRVS-based payment system?"

1 =	____	*Under consideration*	
2 =	____	*Under development*	*continued with*
3 =	____	*Undergoing implementation*	*survey*
4 =	____	*Implemented*	
5 =	____	*Decided not to adopt*	*did not continue*
6 =	____	*Have not considered*	*with survey*

Those payers that selected 5 **(decided not to adopt)** or 6 **(have not considered)** did not continue with the rest of the survey. All other payers were asked to continue.

The second portion of the survey dealt directly with the application and design of RBRVS at the organizational level. All questions were phrased to accommodate the various stages of implementation that respondents were in at the time of the survey. Some payers had already completed implementation while others were still considering implementation. Therefore, payers were asked to indicate what they *"will or are doing"* in a number of areas.[4]

Several issues may need to be addressed before RBRVS fee schedules are used in these new payer environments. Many decisions made by Medicare -- like those regarding relative value units (RVUs), conversion factors, payment policies -- were made in the context of the program's goals, beneficiary population, benefit package, and budget constraints. Each of this issues can vary from payer to payer, thus, we were interested in determining the adjustments made by other payers.

Payers were asked to indicate if any modifications were made to the Medicare RVUs, and if so, how many. The were given the opportunity to select from several areas of medicine to show where these modifications occurred. Inquiries were also made regarding the use and development of conversion factors. We anticipated that many payers would be using more

[4]See appendix for a copy of the survey.

than one, and in some cases, several conversion factors to transform RVUs into actual dollar fees.

The survey included a section on the use of Medicare's payment policies that are associated with the resource-based relative value scale. This section did not exhaust the entire spectrum of payment policies and protocols, yet it did address several important issues. They include the use of:

- Surgical service definitions (i.e. global packages);
- Anesthesia payment system (i.e. based on time spent);
- Nonpayment of EKG interpretation (no longer applicable);
- Site of service (i.e. office vs. hospital out-patient) differentials ;
- Payment method for assistant as surgery;
- Volume performance standards; and
- Budget neutrality.

The survey also included a handful of questions regarding the organization's current methods of physician payment and cost-control techniques. Finally, payers were asked to describe their timeline for implementation -- would an RBRVS system be implemented over a period of time (e.g., five years as Medicare has done) or would it be implemented all at once.

2.2 Case Study Analysis

The Deloitte & Touche survey probably represents the largest single source of information, in terms of breadth, regarding the use of RBRVS by non-Medicare payers. While this information is extremely valuable and useful, gathering of detailed, technical information was very limited within the constraints of this voluntary survey. Considering that the vehicle for collecting this information was a mail survey, we were restricted to gathering information that was generally quantitative and brief in nature.

To complement the information collected in the survey, we conducted a series of in-depth case studies with both public and private payers. The case-study method is an excellent tool for obtaining information that is more detailed and qualitative. Case studies provide a wealth of descriptive data elements and give the researcher an understanding of the context of the environment in which the program is placed. Such issues range from the economic and political environment to the historical development of physician payment in a particular state or region. Most importantly, conducting a case study provides useful insight into the process which was used to develop the RBRVS system.

We conducted our case studies only with payers which were actively developing an RBRVS-based payment system or had already implemented it. For public payers, we studied three Medicaid programs (Washington, Michigan and Virginia) and two workers' compensation programs (West Virginia and the Office of Workers' Compensation Programs/Federal Employees' Compensation (OWCP).[5] We also interviewed the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which pays for care obtained in the civilian sector by several million military beneficiaries. In the private sector, we studied three traditional indemnity insurers and three preferred provider organizations for a total of 12 case studies. Some of the private payers agreed to participate under the condition that their organization's name would remain confidential.

Four distinct case study protocols were developed for each type of payer because it was necessary to collect somewhat different information depending upon the payer's individual characteristics, including their strategic goals and the population they serve. The case studies involved: (1) an initial telephone contact; (2) the applicable protocol being sent to the payer; (3) a 30-45 minute telephone conference call with the payer's representatives; and (4) review and comment of the case study report by the payer. Each individual case study is contained in Section 4.0.

[5] OWCP is the worker's compensation program for federal employees.

3.0 SURVEY FINDINGS

This chapter of the report presents findings based on our analysis of the Deloitte & Touche survey data. Section 3.1 provides a broad overview of payers that are adopting an RBRVS-based payment system. Sections 3.2 and 3.3 break down these findings by type of payer, with Section 3.2 reporting on data from the public sector (state Medicaid programs) and Section 3.3 presenting results from the private sector. Section 3.4 is a synthesis of the survey results.

Throughout this report, we will use the same definition of the word "adopter". We define an adopter as a payer which has already implemented, is in the process of implementing or is developing an RBRVS-based payment system. A "non-adopter" is defined as a payer that has not adopted or has not considered an RBRVS-based payment system. Payers that are still considering adoption are not included in the adopter or non-adopter category, but make up a distinct category of their own for purposes of analysis.

3.1 Adopter/Non-adopter Comparison

The overall diffusion of RBRVS-based payment systems is quite sizable and continues to grow in both the public and private sectors. Of the 333 payers that responded to the Deloitte and Touche survey, one-third (n = 112) are adopting an RBRVS-based payment system (See Exhibit 2). These payers cut across all spectrums in terms of type of payer, organizational size, geographic location and many other identifiable characteristics. Of the adopters, one half have already completed implementation of their system, and the other half are currently developing or implementing it (See Exhibit 3).

One-fourth (n = 90) of the payers that responded are not adopting an RBRVS-based payment system, while the remaining 40 percent of the payers are considering it. Most of the non-adopters are payers that have never considered RBRVS as an option for physician payment at their organization. Because of this, we anticipate RBRVS-based systems will spread further into untapped markets. However, there is a recognizable cohort of payers that have considered this method and specifically decided not to incorporate it. Their reasons are probably quite individualized, based on specific organizational goals, characteristics and financial structure. The D & T survey did not focus *per se* on reasons why payers did not adopt RBRVS, yet significant emphasis was placed on payers' perceptions of the benefits and drawbacks of this approach.

Adopters and non-adopters agree that the potential benefits/goals of RBRVS are attractive to them, but they prioritize them differently. Exhibit 4 shows how the adopters and

non-adopters rank some of the potential benefits of RBRVS. Consistently, adopters look more favorably on each benefit.

Benefits that are most attractive, and presumably had an impact on payers' decision to adopt RBRVS, are the system's ability to (1) rationalize physician payment and (2) reward primary care physicians. In fact, two-thirds of the adopters, but only one-third of the non-adopters, selected rationalizing physician payments as being "highly important". Rewarding primary care physicians is the second most commonly cited benefit by adopters (56 percent); with agreement from 39 percent of non-adopters.

Both groups felt similarly about cost-control -- nearly half of all payers (adopters and non-adopters) chose it as a substantial benefit. There seems to be widespread expectation that an RBRVS-based system will be able to control costs. But cost containment is not assured because dollars may simply be reallocated across physician groups with no impact on overall spending. Some cost-containment may result from reducing administrative complexities, but savings are likely to be trivial. Payment policies that are implemented, or not implemented, along with an RBRVS system (most notably budget neutrality) will probably have a greater impact on cost containment.

Exhibit 5 shows a comparison of the percent of adopters and non-adopters that consider the drawbacks of RBRVS to be "highly important". Not surprisingly, very few adopters see any major drawbacks of adopting RBRVS. Of greatest concern to them (14 percent of adopters) is disrupting physician relations. This indicates that although these payers have gone forward with adoption, they are still concerned about its impact on their physician retention rate and satisfaction levels.

The non-adopters most often rank the relative newness of the system to be a very important factor in their decision making, followed by costs of converting to RBRVS, lack of expertise, and then disrupting physician relations. For all the drawbacks, except disrupting physician relations, the adopters are significantly less likely to be as concerned. It appears that payers adopting RBRVS are more impressed by the positive aspects and less disturbed by the negative ones. Furthermore, there seems to be specific benefits and drawbacks that are influencing adoption of RBRVS.

Exhibit 6 shows how the 112 adopters are distributed among the eight payer categories. Categories with the highest percent of adopters are Blue Cross/Blue Shield plans, PPOs, and IPA-model HMOs. In fact, 40 percent of the adopters in this study are IPA-model HMOs; while PPOs and BC/BS each captured 17 percent of the adopter pie. Penetration was lowest among third-party administrators and indemnity insurers, and not a single self-insured corporation in the sample had adopted an RBRVS-based system.

The payer groups we found to be adopting RBRVS more frequently have specific structural and philosophical differences from their non-adopting counterparts. Managed care and Blue Cross/Blue Shield plans are known for their use of physician participation agreements whereby physicians agree to accept provider payment as payment in full. As a result, they are not concerned with potential balance billing. However, this concern still exists for payers without physician participation agreements. We find that balance billing serves as a significant barrier to adoption of RBRVS.[1]

Exhibit 7 shows the percent of adopters within each payer category that are adopting an RBRVS-based payment system. It is important to examine the data in this fashion as a result of the unequal distribution of respondents in each payer category. [2] However, the results show the same three groups of payers (BC/BS, PPOs, and IPA-model HMOs) to be the most active in RBRVS adoption. When data from the original and follow-up D& T surveys was combined, we discovered that about one-third (15 of the 48) of Medicaid programs contacted are adopting RBRVS-based payment systems.

Penetration of RBRVS is also more common in managed care *products* as opposed to indemnity *products*. Exhibit 8 (far left column) shows the private payers that are adopting RBRVS and the products to which they are applying it. Many of the adopters have multiple product lines, but tend to only implement RBRVS in their HMOs, PPOs, or Point of Service (POS) products. RBRVS is rarely applied in the indemnity market although it does occur to a limited degree, mainly in the case of BC/BS.

Our analysis resulted in the identification of patterns of RBRVS adoption with respect to other organizational characteristics as well. Exhibit 9 shows the geographic coverage areas of the adopters. Nearly one-third provide their services in the Midwest while one-fourth are concentrated in the West. As with diffusion by payer type, it was necessary to calculate the percent of adopters in each region individually because the number of payers differs by region. Exhibit 10 shows the percent of respondents within each region that are adopting RBRVS. Again, the highest penetration of RBRVS is in the Midwestern and Western part of the country, where the penetration of managed care is known to be high as well, particularly in California, Washington, Minnesota, and Wisconsin. Of the 84 payers in the Midwest, 43 percent have adopted an RBRVS-based payment system; similar to 43 percent of the payers in the West (30 out of 70). The region with the lowest percent of adopters is the South; and one-fifth of the nationwide payers have moved forward in this direction.

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[1] Balance billing is a policy decision and is distinct from RBRVS. This lack of distinction by payers is consistent with their perception that the MFS and RBRVS are synonymous.

[2] Because all denominators in the categories of the sample are different, it is more meaningful to look at the percent of adopters in each payer category individually.

As shown in Exhibit 11, the adopters average more enrollees and have significantly higher expenditures for physician services compared to non-adopters. It is possible that the adopters' larger size provides market power which is helpful in adopting RBRVS. However, this hypothesis did not hold for payers in terms of physician size.

Program Design

Many payers are adopting a system based on Medicare's RBRVS, yet not all will implement other elements of Medicare's physician payment system -- including (all of) its Relative Value Units (RVUs), conversion factor (CF) or related payment policies. The nature of each system will depend on which (and to what degree) these components are accepted or modified.

Considering that most payers in this study did not adopt RBRVS until late 1992 or early 1993, it is not surprising to find that nearly one-third of those responding are still undecided about many design elements. Furthermore, nearly one-half of the adopters are phasing in RBRVS, providing more time to decide on specifications, as opposed to implementing it immediately. Phase-in periods range from a couple of months to five years, with a median range of approximately 1-3 years. Directly below we present a brief summary of the respondents' implementation strategies.

Payers are clearly divided regarding modifications to Medicare's RVUs. One-third of adopters are making changes to the RVUs, the same amount are making no changes, and another third are undecided. There was extremely limited response to the question regarding the actual number of RVUs to change; however, most respondents answered that it would be less than 100. The area in which modification is most likely to occur is Obstetrics/Gynecology (OB/GYN). Other areas of modification generally include Pediatrics, Surgery, and Pathology.

Nearly 60 percent of the adopters are using multiple conversion factors (CFs) to convert their relative values into dollars. The most common basis used to determine multiple conversion factors is geography, but 'areas of medicine' or 'physician specialty' were cited as well.

The most frequently adopted of Medicare's payment policies were surgical service definitions and the payment method for assistants at surgery which were implemented by about 40 percent of respondents (See Exhibit 12). Very close behind is implementation of RBRVS on a budget-neutral basis (where total physician payments will not differ from those that would result from a continuation of the current system). This policy differed significantly according to type of payer. Very few respondents reported adoption of Medicare's Volume Performance Standards. Exhibit 12 also shows the vast amount of uncertainty regarding all of the policies -- for every payment policy, one-third of adopters are undecided.

In the sections that follow, a more-detailed description of findings is provided. Sections are organized by type of payer. The first portion of each section discusses the characteristics of that payer group and the diffusion of RBRVS within that group. The second portion reviews the general design of the systems being adopted or considered. Under "Program Design", we indicate if the payer group is making modifications to Medicare's RVUs; how many conversion factors are generally used; and which payment policies are being implemented. [3]

3.2 Public Payers

3.2.1 State Medicaid Programs

Since November 1992, when the Physician Payment Review Commission (PPRC) completed similar research indicating that nine state Medicaid programs had implemented or were implementing Medicare's relative value scale, a half dozen additional states have joined this group (PPRC, 1993). Although some are still in the developmental stages, a total of 15 of the 48 state Medicaid programs contacted have made a definitive commitment to use RBRVS-based payment systems (See Exhibit 13). Eight states have completed implementation while the remainder are either developing or implementing their systems.[4] Florida, Indiana, and West Virginia are aiming to complete implementation by July, 1994.

Four additional Medicaid programs are using RBRVS, but in a limited fashion. For example, Hawaii is using RBRVS as a cap, commonly referred to as the "maximum allowable" charge, and Iowa is using Medicare's RVUs only for radiology services (CPT 70000 series) along with a budget neutral conversion factor. Maine uses work components calculated by an earlier Hsiao study to derive set dollar amounts for its payment rates.

The Medicaid programs adopting RBRVS, like all Medicaid programs, vary tremendously in terms of size -- both in the number of physicians and enrollees, not to mention expenditures. Taken together, the "full-scale" adopters pay approximately 120,000 physicians for the services provided to Medicaid beneficiaries. This same group of states has 12.6 million eligibles whose medical care by physicians would be paid under an RBRVS-based system. Up from one-fourth in November, 1992 (PPRC, 1993), about one-third of all physicians in the Medicaid program are now being paid through a system similar to Medicare's.

Twelve additional state programs are considering adoption of RBRVS. Oregon and Utah have decided to go forward with RBRVS since reporting in the PPRC study that they were actively exploring it. Connecticut, Indiana, Rhode Island, Utah, and West Virginia have

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[3] Sub-sections entitled "Program Design" include responses from adopters and also from payers considering RBRVS.

[4] Most of Arizona's Medicaid enrollees are in managed care plans and will not be affected by the RBRVS system which is used for its small fee-for-service population.

recently decided to adopt the RBRVS system and are now in the development stage. The only states considering RBRVS at the time of the PPRC survey and decided not to adopt it are Vermont and Tennessee.

The adopters represent all regions of the country (See Exhibit 14). In one way or another, 19 state Medicaid programs are directly influenced, some more than others, by the Medicare fee schedule. The main reason states find RBRVS attractive is its ability to reward primary care physicians through the use of relative weights that increase reimbursement for primary care services (see Exhibit 15). This system is cited as being more rational than other traditional systems based on charges. In addition, some Medicaid programs view having a system that is comparable to Medicare's (and is nationally recognizable) as beneficial. A direct advantage of having a comparable system is that states will not have to dedicate resources to updates, but can rely on Medicare for this.

We found that 17 state Medicaid programs are not adopting RBRVS - nine have not yet considered it and eight others have specifically decided against it. The area of greatest concern among the non-adopters is the relative newness of RBRVS (see Exhibit 16). Another area of significant concern is payment for OB/GYN and pediatric services. Considering that these services are a focal point for Medicaid programs, their anxiety seems justifiable. The population served by the Medicare program is quite different from the Medicaid population and RVUs for some services in the MFS are now under review by HCFA and the AMA RVU Update Committee (RUC).

Program Design

With respect to the use of Medicare's RVUs, only a few states reported making modifications. When changes were made, only a limited number of RVUs were affected in each state program. The areas affected by RVU modification were OB/GYN, Pediatrics, Surgery, Rehabilitation, and Emergency Medicine. Many states, such as Ohio, Georgia, and Michigan did not modify any of Medicare's RVUs. Texas established some if its own Access Based Fees (ABFs) for services that were viewed as undervalued (Coburn *et al.*, 1992).

Instead of modifying RVUs, some states lean toward using multiple conversion factors to impact fees in specific areas. For instance, Oregon and Washington have separate CFs for OB/GYN services.[5] The states are equally divided on the use of single versus multiple conversion factors. While some private payers are basing their multiple conversion factors (CFs) on geographical areas, no Medicaid program has taken this approach, presumably because all payments are within the same state. However, some large states, or those with

[5] Washington state uses four different conversion factors.

great diversity in the distribution of wealth and costs, may be more inclined to geographically adjust their payment levels.

Several of the Medicare payment policies being adopted by state Medicaid programs are shown on Exhibit 17. They include: (1) payment of non-physicians[6] (eight adopted); (2) assistant at surgery (seven adopted); (3) surgical service definitions (six adopted); and (4) non-payment of EKG interpretations (five adopted). Three programs implemented site-of-service differentials and most are uncertain about adopting Medicare's anesthesia payment system. None elected to use Volume Performance Standards.

In addition to improving equity, which was their most important goal, some programs expect to realize other positive outcomes with RBRVS adoption. For example, programs are expecting to see improved quality and utilization from their recent payment system changes.

3.3.1 Traditional Indemnity Insurers

Twenty-seven traditional indemnity insurers responded to Deloitte & Touche's RBRVS survey. In total, these organizations provide health care to over ten million enrollees and paid out over three billion dollars for physician services in 1992. Nearly two-thirds of these insurers have physician networks throughout the US. Thus, the decisions they make regarding how they provide and how they pay for health care services have a sizable impact on the overall market.

Enrollees in these insurers' plans receive their care through a variety of arrangements. Specifically, the products offered by these "traditional" indemnity insurers include fee-for-service arrangements, but is highly reflective of the industry's shift toward managed care. In fact, the indemnity insurers in the sample offer as many PPO products as they do indemnity products. Managed indemnity products are also a large part of their business.

About half of the group indicated that their 1992 physician expenditures were higher or much higher than previous years. Interestingly though, eight of the 27 payers reported having payments in 1992 that were lower than previous years. This decrease may be attributed to a shift toward managed care products which often have lower premiums (Gabel and McCormack, 1992).

About 80 percent of indemnity insurers in the sample currently rely on at least one outside source of information, such as the Health Insurance Association of America's (HIAA) payment values or McGraw-Hill's Relative Values for Physicians (RVP), to establish or evaluate their physician fee schedules. Their present cost-containment mechanisms include a variety of

[6]Not shown in Exhibit 17.

utilization review mechanisms with the greatest reliance on in-house claims review by non-clinical staff and unbundling and other software review systems.

Exhibit 18 shows how the indemnity insurers rank the benefits of RBRVS. Three-fourths of respondents indicated that avoiding cost-shifting is a very important benefit of adopting RBRVS. They anticipate that physicians may try to recoup losses --experienced as a result of some payers adopting RBRVS -- by charging non-adopters higher rates. The indemnities felt the strongest about cost-shifting above all other groups and all other benefits. Respondents also reported dissatisfaction with their current system as an important benefit of switching to RBRVS. According to Exhibit 19, they perceive the two greatest drawbacks to be (1) the newness of the system and (2) the expertise required to implement it.

Of the twenty-seven indemnity insurers, five indicated that they are adopting an RBRVS-based payment system and another 16 indemnities are considering it. All 21 of these payers continued with the second portion of the survey dealing with program design. No indemnity insurer in the survey adopting RBRVS is applying it to their indemnity line of business, although several of the sixteen payers considering RBRVS have not ruled out this possibility. Two of the adopters are applying RBRVS to their managed indemnity business, indicating that RBRVS may eventually seep into the indemnity sector. These payers are generally applying RBRVS to more than one product line at a time.

Program Design

Of the five indemnity adopters, two modified Medicare's RVUs and two others did not (the other is undecided). One of the payers that chose to modify did so for over a 1000 RVUs. The indemnity insurers adopting or considering RBRVS were divided on the use of multiple conversion factors (CFs). Those in favor of using more than one CF prefer geographical areas as a basis for differentiation. Most respondents in these groups are unsure whether they would implement RBRVS on a budget neutral basis, but two adopters have already done so.

The theme of uncertainty is similar regarding adoption of payment policies that Medicare implemented along with RBRVS. As can be seen is Exhibit 20, substantial indecision exists with the exception of Medicare's Volume Performance Standards (VPS), which all indemnity insurers rejected. For most of Medicare's payment policies, payers in this group had not decided what they would do.

3.3.2 Blue Cross/Blue Shield Organizations

According to the Blue Cross and Blue Shield (BC/BS) Association, the Chicago-based national association for Blues plans, there are 73 BC/BS plans in the US. There were a total of

64 BC/BS plans in the Deloitte & Touche sampling frame. Of these, 24 responded to the survey, and 19 indicated that they are adopting some form of an RBRVS-based payment system. BC/BS survey respondents are from all regions of the country, but one-half (n = 12) are from the West. The plans offer a variety of product lines ranging from traditional indemnity to managed care options.

In order to estimate the impact of decisions made by payers, they were asked to provide statistical and financial information on the number of physicians and enrollees in their plan and their organization's total payments for physician services in 1992. The 24 Blue Cross and Blue Shield plans that responded employ approximately 170,000 physicians, cover 17.3 million enrollees, and paid out approximately four billion dollars in (physician) claims in 1992. Over 90 percent indicated experiencing increases in expenditure outlays in 1992 which were "slightly higher" than previous years.

When the plans were queried about six possible benefits of RBRVS, their top two responses were the same as the Medicaid programs -- rationalizing physician payment and rewarding primary care physicians (see Exhibit 21). The Blues are traditionally known for having good relationships with their physicians. It is not surprising then, to find that disrupting physician relations is viewed as RBRVS's main drawback. No BC/BS plan expressed high disagreement with the RBRVS methodology or concern about conversion costs (See Exhibit 22).

RBRVS penetration exists across all types of the Blues indemnity and managed care products. Ten of the nineteen adopters are applying it to their indemnity line of business. Not only do many BC/BS organizations have participating physician agreements that exclude balance billing, but they also have substantial market share within their state. Meeting both of these conditions may make application of RBRVS to indemnity products much more plausible.

Program Design

The Blues plans are no further along than other payer groups in terms of decisions regarding RBRVS program design. One-third are modifying Medicare's RVUs, one-fourth are not, with the remaining 40 percent still undecided. The areas most frequently specified for modification are the same as other payers -- OB/GYN and Pediatrics. There was a preference for using multiple conversion factors. Plans using more than one CF are adjusting fees geographically. BC/BS is the payer group implementing RBRVS on a budget-neutral basis most frequently (60 percent of the time).

As with most other payer groups, Medicare's payment policy regarding non-payment of EKG interpretations and Volume Performance Standards (VPS) are quite unpopular.

Medicare's surgical service definition is a clear winner (nearly half are adopting it). The degree of certainty regarding other policies tapered off after these three policies (See Exhibit 23).

3.3.3 Managed Care Organizations

Although the Deloitte & Touche sampling frame included 323 Staff and Group-Model HMOs, only 10 responses were received. As a result of this very low sample size, the report does not include a complete analysis of RBRVS diffusion in this payer arena. However, this section begins with a short overview of information obtained from the 10 Staff/Group-model HMOs, then moves directly into our findings from IPA-model HMOs and Preferred Provider Organizations (PPOs).

The limited response by Staff/Group-model HMOs is most likely a function of their market's lack of interest in this type of payment system. Yet, two of the ten respondents have implemented an RBRVS-based payment system -- but, both of these HMOs were Group-model and not Staff-model HMOs. In general, the 10 Staff/Group-model HMOs that responded did not perceive many of the benefits or drawbacks of RBRVS as highly important. It is unlikely that Staff-model HMOs find a resource-based payment mechanism attractive or necessary because their physicians are paid on a salaried basis, and they already have an emphasis on primary care.

IPA-model HMOs, on the other hand, are very interested in RBRVS as demonstrated by their much higher response rate and adoption rate. IPA-model HMOs are the payer category with the highest level of RBRVS adoption: nearly one-half of respondents (43 of 87 IPAs) are adopting. In contrast to HMOs which pay physicians on a salaried basis, most IPA-model HMOs pay on a fee-for-service basis, contracting directly with physicians (or associations of physicians) in independent practices. This characteristic, along with their ability to restrict balance billing, makes them better candidates for RBRVS.

The IPA-model HMOs and PPOs in the sample represent all regions of the US and offer all types of managed care products. Together, the 87 HMOs that responded pay approximately 200,000 physicians and cover 16.7 million insured lives. The survey's 51 PPOs cover 350,000 physicians and provide care to 31 million enrollees. Similar to IPA-model HMOs, PPOs contract with groups of physicians to furnish services at negotiated fees in return for prompt payment and a guaranteed patient volume. Theoretically, PPOs control costs by keeping fees down and curbing excessive service through tight utilization review (UR) (Reynolds and Bischoff, 1990). Yet, realistically, PPOs have had trouble meeting this goal simply by relying on discounts and UR (Rice and Gabel, 1990). This was reinforced by our finding that 85 percent of the PPOs experienced higher or much higher expenditures in the last

year. Our findings show that PPOs are interested in RBRVS: 37 percent of respondents (19 of 51 PPOs) are adopting.

PPO and IPA perceptions of the benefits and drawbacks of RBRVS are both similar to each other and close to the norm of most adopters. The most highly regarded benefit of RBRVS is its ability to rationalize physician payment, followed closely by rewarding physicians payment (See Exhibits 24 and 27). The drawbacks which cause the most concern for both groups include (1) the newness of the system and (2) its impact on physician relations (see Exhibits 25 and 28).

Program Design

Half of the managed care organizations in the survey modified the Medicare RVUs and the other half did not. For those which modified, the range was quite large -- anywhere from 1 to 6,000 RVUs were changed-- but most modified less than 100. As with most RVU modification, the areas of OB/GYN and Pediatrics were affected to the largest degree, with Pathology and Surgery close behind. This payer group was the most decisive regarding use of multiple conversion factors. Forty percent of the IPA-model HMOs and 60 percent of PPOs are (or would) use them, adjusting mostly on a geographic basis.

Second only to BC/BS, forty percent of IPA-model HMOs are implementing their system on a budget neutral basis. PPOs are less likely to do this; only one-fourth indicated a preference for budget neutrality. The managed care payer group adopted several of Medicare's payment policies -- more than the adopters overall. As shown in Exhibits 26 and 29, the most popular are surgical service definitions, payment method for surgical assistants and site-of-service differentials.

3.3.4 Self-funding Organizations

Third-party administrators (TPAs) act as agents of self-insured companies and provide them with administrative services and claims processing. They may also manage the company's reinsurance pool. Although TPAs are not direct payers of physicians claims (because they use corporate dollars to pay for incurred expenses), they often have an influence on how physicians are paid. It is actually the TPA which makes many of the decisions on the company's insurance policies and physician reimbursement. Both TPAs and self-insured corporations were included in the Deloitte & Touche survey.

None of the 24 self-insured companies in the study is adopting RBRVS, although these companies did provide some useful information about the corporate perspective in this area of

health care. Sixty-eight TPAs responded to the survey -- ten of them are adopting RBRVS and over one-half of the remainder are currently considering it.

The TPAs and self-insureds both view the main benefit of RBRVS to be cost-control and as a means to this end, avoiding cost-shifting (See Exhibits 30 and 33). In fact, 70 percent of the self-insureds see cost-shifting as a very important reason to adopt RBRVS. This percent is nearly twice as high as the overall mean response to this question (40 percent), but is similar to the response given by indemnity insurers (77 percent). Many self-insured companies have large enrollee (and retiree) populations along with rich benefit packages; thus they have been hard hit by increasing premiums over the last decade. It appears that they believe RBRVS has the capability to control costs.

In terms of RBRVS's drawbacks, nearly one-third of the self-insureds and 28 percent of the TPAs feel that the system is too new. About one-fourth of the TPAs were also concerned with the costs of converting to an RBRVS-based payment system. The self-insureds view their lack of expertise in this area as a drawback. Otherwise, both the TPAs and self-insureds view of the drawbacks is similar to each other and the other payer groups.

Since no self-insureds in the sample are adopting RBRVS, we discuss RBRVS implementation by the 47 TPAs (10 adopting and 37 considering) that continued with the survey. The TPAs offer both indemnity and managed care products. Of the 10 TPAs which are adopting the new system, eight are applying it to their PPO products. Some are also using RBRVS for other managed care products including managed indemnity plans and four TPAs *are* applying RBRVS to their indemnity products. Beside ten BC/BS plans, one HMO and one state Medicaid program; this the only evidence in our study of RBRVS diffusion into indemnity products (see Exhibit 5). A question which requires future investigation is how the TPAs are addressing balance billing limitations.

Program Design

For the TPAs, there is greater preference for the use of multiple conversion factors. This is not exclusive to TPAs, but is a common finding across all payer types. This strategy is perhaps one way to ease apprehension regarding implementation. Most TPAs were undecided about whether to modify RVUs; yet for those which have decided, a small majority will make some modifications.

One of the ten TPAs implemented their system on a budget-neutral basis. The most commonly adopted payment policies are those related to surgical services. Few other policies were popular with this payer group. However, one TPA did implement all of the payment policies of which they were queried, including non-payment for EKG interpretations and VPS.

It will be interesting to see if TPAs and other payers keep the EKG policy which has been recently rescinded by Congress for Medicare.

3.4 Synthesis of Survey Findings

Medicare's Resource-Based Relative Value Scale (RBRVS) has diffused into the Medicaid and private sectors. For many of the same reasons as Medicare, a surprising number of payers have already adopted an RBRVS-based payment system; and several others are currently considering it. The diffusion of RBRVS has moved across the spectrum of payer types, product lines, and regions. Yet, a great deal of uncertainty remains in several areas, particularly with respect to Medicare's payment policies.

Of the 333 payers that responded to the survey, three-fourths are either adopting or considering adoption of an RBRVS-based payment system. One hundred and twelve payers are actually adopting it, of which one-half have already completed implementation. Only nine percent of the respondents had specifically rejected RBRVS; and another 20 percent have yet to consider it. As evidenced by these results, the influence of the Medicare Fee Schedule is much greater than many may realize.

There was very little adoption by indemnity insurers and none by staff-model HMOs and self-insured corporations. The types of payers in the sample most frequently adopting RBRVS are BC/BS plans and managed care organizations. We found that nearly one-third of the Medicaid programs have already have implemented or are in the process of implementing an RBRVS-based payment system. In addition, a few Medicaid programs are using RBRVS as a fee screen or for a subset of their services. Penetration in this market has nearly doubled in the six months between November 1992 and the summer of 1993 when the Deloitte & Touche survey was fielded. RBRVS has penetrated to a higher degree in the Midwestern and Western parts of the country. These are the two regions of the country where there tends to be a higher degree of managed care. RBRVS diffusion is also highest in managed care *products*. In our survey, there are approximately 100 private payers applying RBRVS to approximately 200 health insurance products. About three-fourths of the products to which RBRVS is applied are managed care, and the remainder indemnity-based. Adopters are applying RBRVS to more than one product at a time.

Both adopters and non-adopters are attracted to RBRVS for several reasons. Payers are clearly dissatisfied with their current payment method, most often the Usual, Customary, and Reasonable (UCR) system or some variant of it. Many payers want to move away from this inherently inflationary system to a more rational and equitable one. This is the number one goal of the respondents adopting RBRVS.

More than one-half of the adopters surveyed see cost-containment as another vital benefit of adopting RBRVS. Surprisingly, only five percent are adopting Medicare's Volume Performance Standards (VPS). VPS is the component of Medicare's fee schedule which is responsible for controlling health care spending. (It is assumed that control on the volume side will halt potential spending increases resulting from lower payments for surgical and other services). Many adopters of RBRVS may soon realize that unless RBRVS is complemented by specific policies to address rising costs, a reduction in expenditures may not be achieved.

One-third of adopters are implementing their system on a budget-neutral basis. By doing so, they have explicitly decided that their total payments for physician services can remain the same as they were the prior year -- therefore, no immediate cost-savings can be achieved for these payers. Cost-savings would be accrued over the longer term if adopters limit the rate of growth in the conversion factor.

Respondents were given the opportunity to write in benefits of RBRVS that were not mentioned in the survey. Below are some examples of their responses:

- universal acceptance and ease of maintenance;
- operational ease;
- accuracy in forecasting trends;
- fee management and standardized fee and productivity analysis; and
- consistency of reimbursement.

Hardly any private payers in the survey disagree with the methodology behind the development of RBRVS. In fact, few adopters perceive that RBRVS has any major drawbacks. This is not to say that they are completely free from concern. Our results show the areas of greatest concern are the newness of the system and the possibility that RBRVS may disrupt relations with their physicians. Considering the political climate of health care today, many payers are choosing a 'wait and see' approach before they dedicate resources to a new system. Respondents were also given the opportunity to write in perceived drawbacks not mentioned in the survey. Their responses are as follows:

- complexity of RBRVS regarding multi-product line implementation;
- applies principally to Medicare products;
- RBRVS does nothing to control utilization; and therefore can be circumvented as a cost-control mechanism;
- radiology/pathology/anesthesiology are not complete; and
- balance billing.

State Medicaid programs expressed some apprehension about the RBRVS methodology. Their concern is most likely a reflection of the population their program covers -- a population that is very different from Medicare's. When the RBRVS was developed, few relative values were created for obstetrical and pediatric services, which constitute a large share of Medicaid's services. It was not until July 1993 that RVUs for certain newborn services were proposed by HCFA in the *Federal Register*. HCFA has requested comment on these and other preliminary codes because of the recent interest in RBRVS by state Medicaid programs and commercial insurers. Controversy still exists regarding the validity of some of these RVUs.

An important finding from this analysis is that a great deal of uncertainty remains regarding individual program design and adoption of Medicare's payment policies. Over one-half of respondents are undecided about modifying Medicare's RVUs. Of those payers that have made a decision in this regard, the percent that are modifying is equal to those that are not. This split is consistent across all payer types. Considering the amount of time and expertise used in developing the RVUs, it is understandable that payers may be apprehensive about making any changes.

Overall, 40 percent of payers were unsure whether to use a single or multiple conversion factors to convert the RVUs into dollars. Among the payers that have decided on the number of CFs to use, two-thirds are using multiple conversion factors. By far, the most common basis for the development of multiple CFs is geographical, whereby different regions use the same relative values but each have their own CF.

The conversion factor(s) used, along with the amount of modification made to the relative values, will have a tremendous effect on a system's overall impact. What can also have a potentially large effect are payers' decisions regarding budget neutrality and Volume Performance Standards. How these issues are addressed will set the stage for a payer's ability to control costs, at least initially. Overall, one-half of all adopters are implementing their RBRVS system on a budget neutral basis, but wide diversity exists across payer types. For instance, sixty percent of the Blues plans and only five percent of indemnity respondents favor budget-neutrality. Each payer should expect different results based on these decisions.

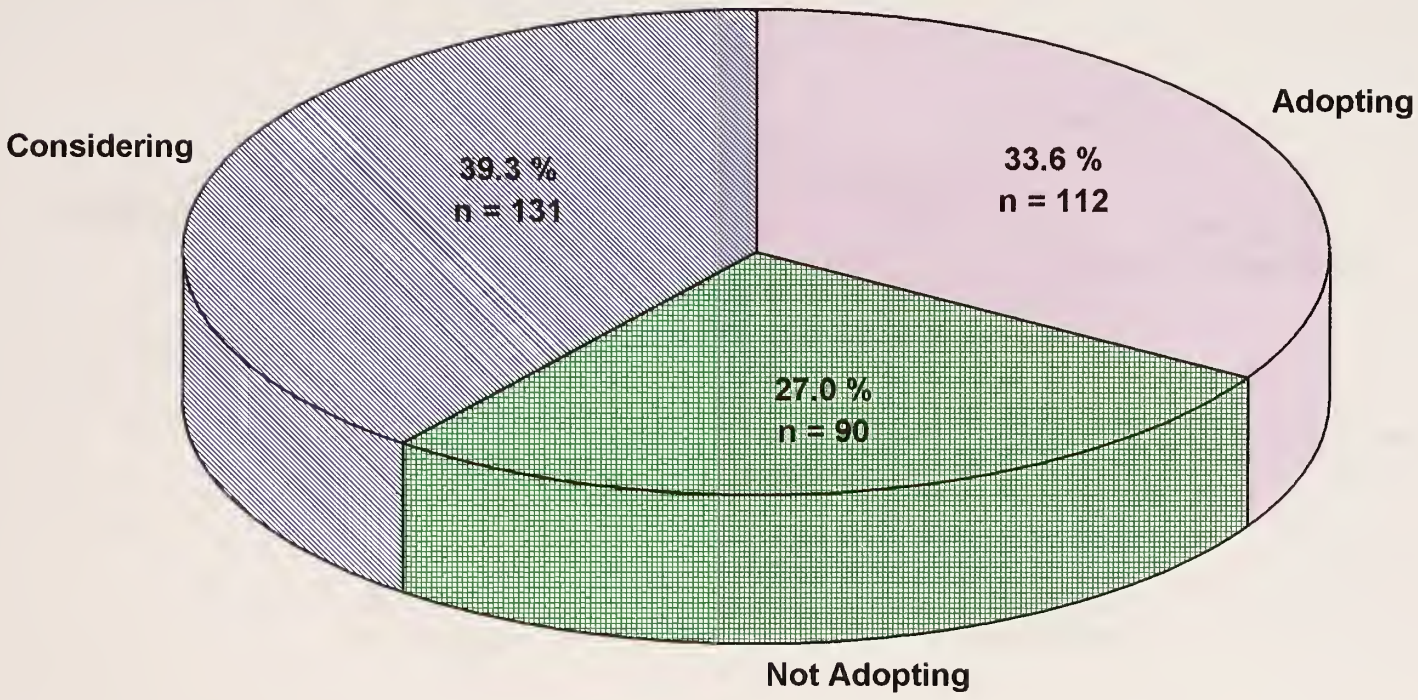
Another important component of payers' systems is the payment policies selected for implementation. The big 'loser' is non-payment of EKG interpretations. Since the Deloitte & Touche survey was fielded, Congress repealed this payment policy for the Medicare program. Policies dealing with surgical services are by far the winners. There is little difference across payer groups, except that indemnity insurers found these policies less attractive.

Four out of every ten adopters are phasing in their system over time. Some payers are phasing it in over several months while others are taking several years. One-third of the payers, however, are not using any phase-in at all. A greater percent of managed care

organizations indicated that they would use a phase-in period, while state Medicaid programs generally prefer immediate implementation.

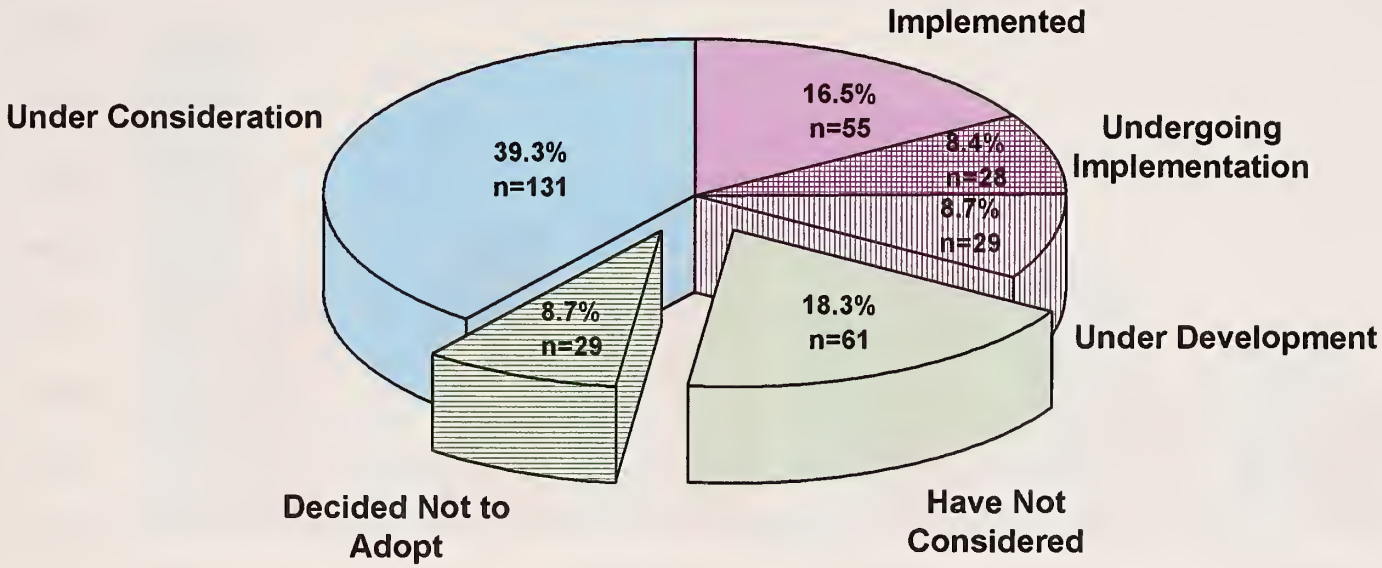
Very limited, if any, data is available on the effects of RBRVS implementation in the Medicare program. However, this analysis shows that RBRVS is moving beyond Medicare despite the lack of proven results. Dissatisfaction resulting from high costs and the inflationary nature of current payment systems are undoubtedly key factors in pushing RBRVS's acceptance. Time will tell whether adoption of RBRVS will achieve the benefits that are commonly associated with it and whether its limitations can be accepted.

EXHIBIT 2
PERCENT OF PAYERS WHICH ARE ADOPTING, CONSIDERING AND NOT ADOPTING RBRVS



n = 333
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 3
EXTENT TO WHICH PAYERS ARE ADOPTING RBRVS



n=333
Source: Deloitte & Touche Survey, 1993.

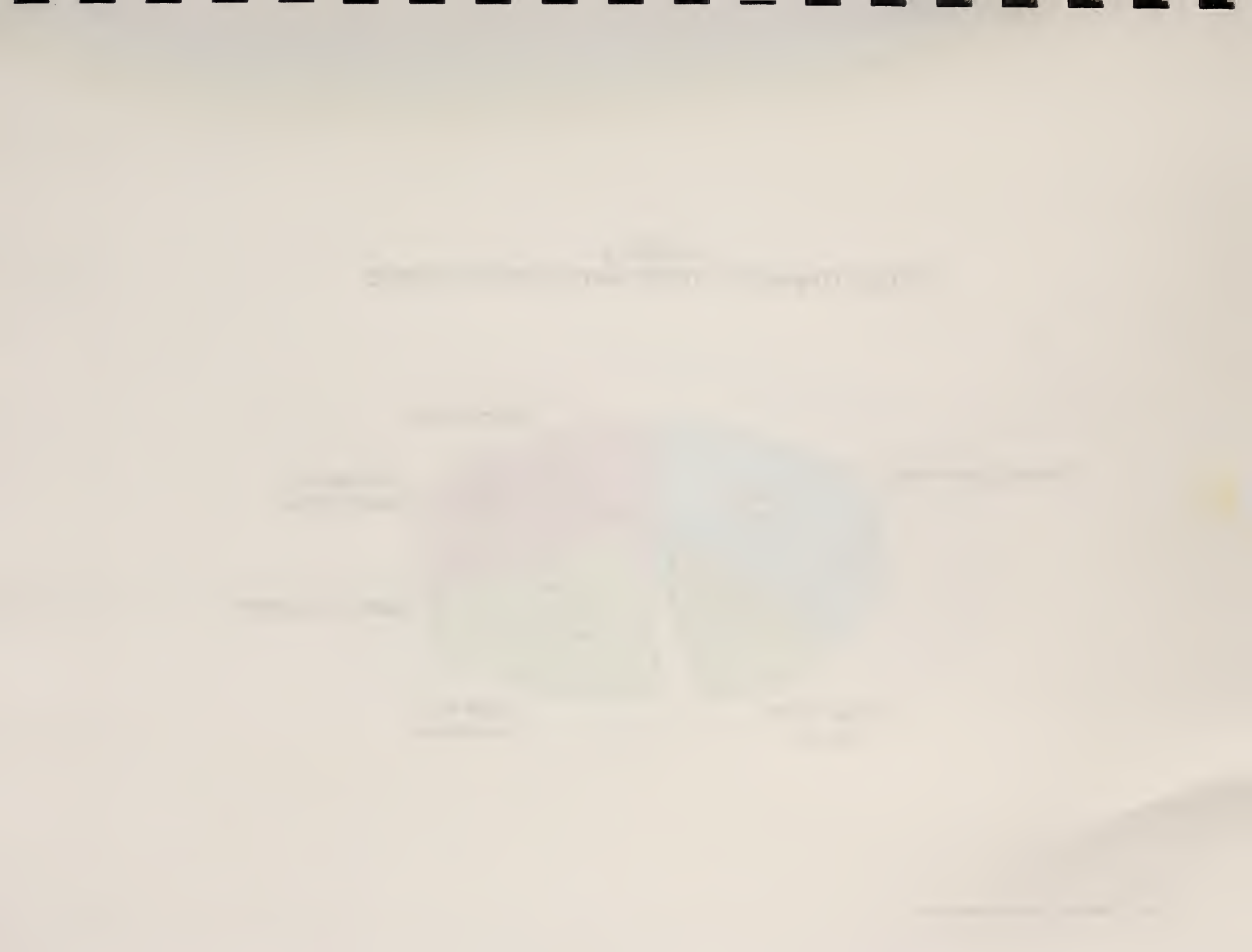
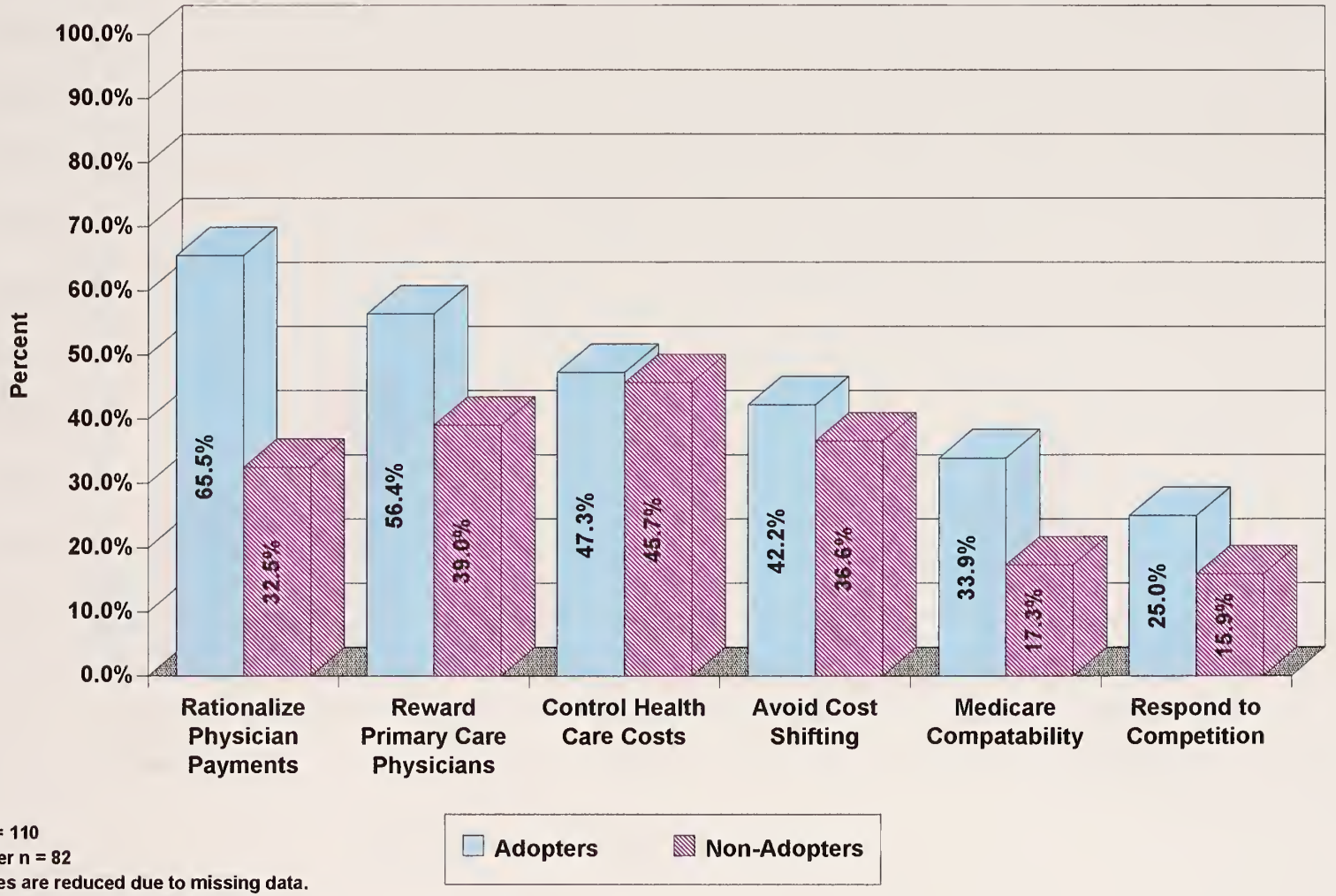
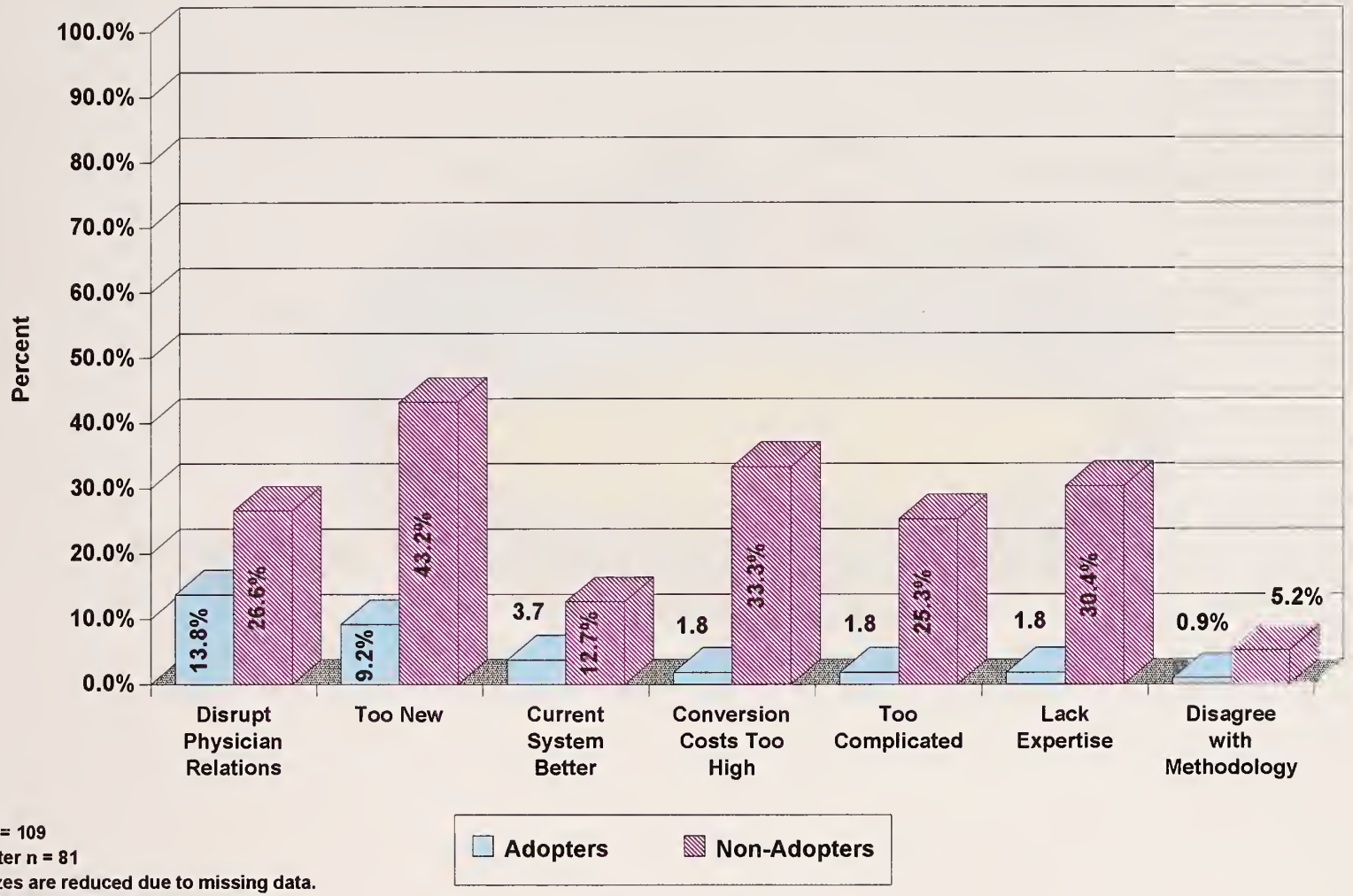


EXHIBIT 4
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: ADOPTER/NON-ADOPTER



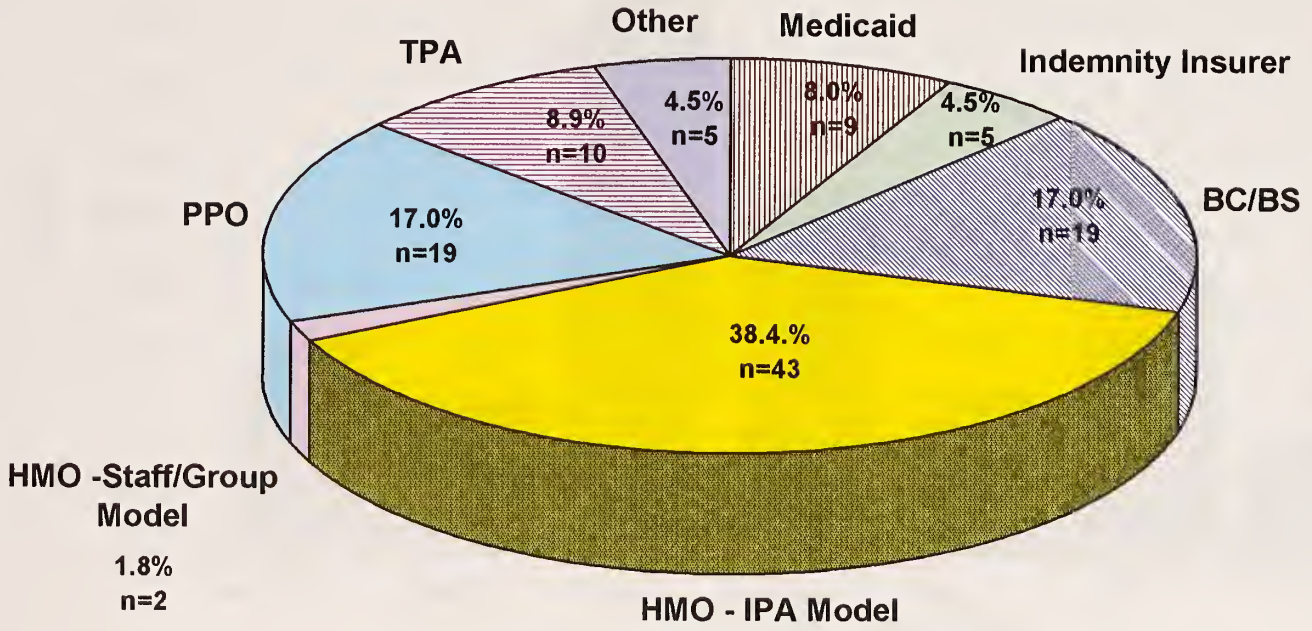
Adopter n = 110
Non-Adopter n = 82
Sample sizes are reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 5
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: ADOPTER/NON-ADOPTER



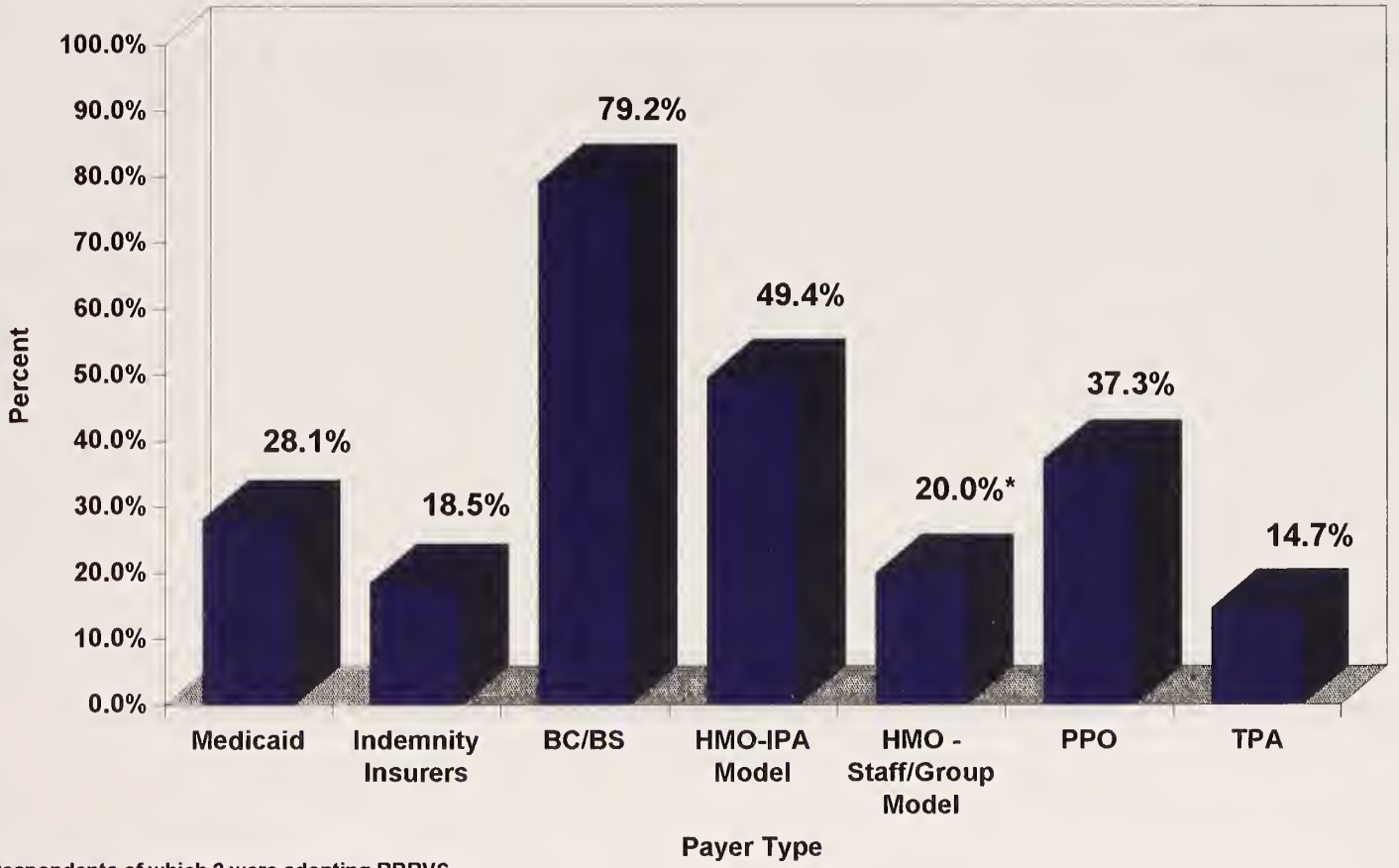
Adopter n = 109
Non-Adopter n = 81
Sample sizes are reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 6
PAYERS ADOPTING RBRVS: BY TYPE OF PAYER



n=112
Source: Deloitte & Touche Survey, 1993

EXHIBIT 7
PERCENT OF RESPONDENTS IN EACH PAYER CATEGORY ADOPTING RBRVS



* There were 10 respondents of which 2 were adopting RBRVS.
n = 107
Source: Deloitte & Touche Survey, 1993.

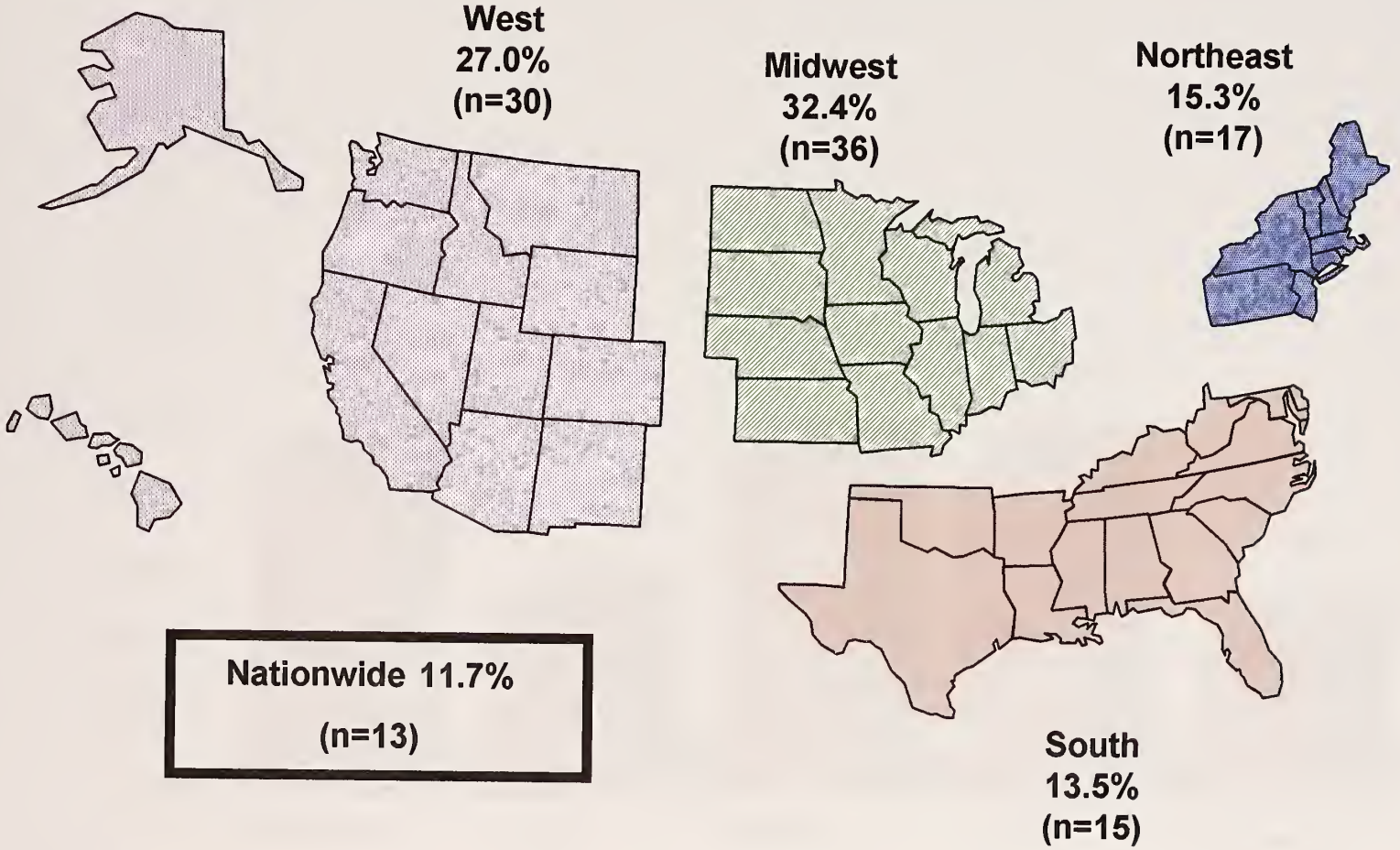
EXHIBIT 8
DIFFUSION OF RBRVS INTO PRIVATE PAYERS' HEALTH INSURANCE PRODUCTS

		Number of Products to Which RBRVS Applies					
	Total # of Payers	Traditional Indemnity Plan	Managed Indemnity Plan	HMO Product	PPO Product	Point of Service Product	Total # of Products
Indemnity Insurers	5	0	2	2	4	1	9
Blue Cross/Blue Shield	16	10	12	9	14	10	55
HMO - IPA Model	43	1	6	41	12	25	85
PPO	19	0	1	2	19	5	27
TPA	10	4	6	2	8	5	25
Overall n	93	15	27	56	57	46	201
Percent Distribution		7.5%	13.4%	27.9%	28.4%	22.9%	100.0%

Note: A payer may offer more than one product line.

Source: Deloitte & Touche Survey, 1993.

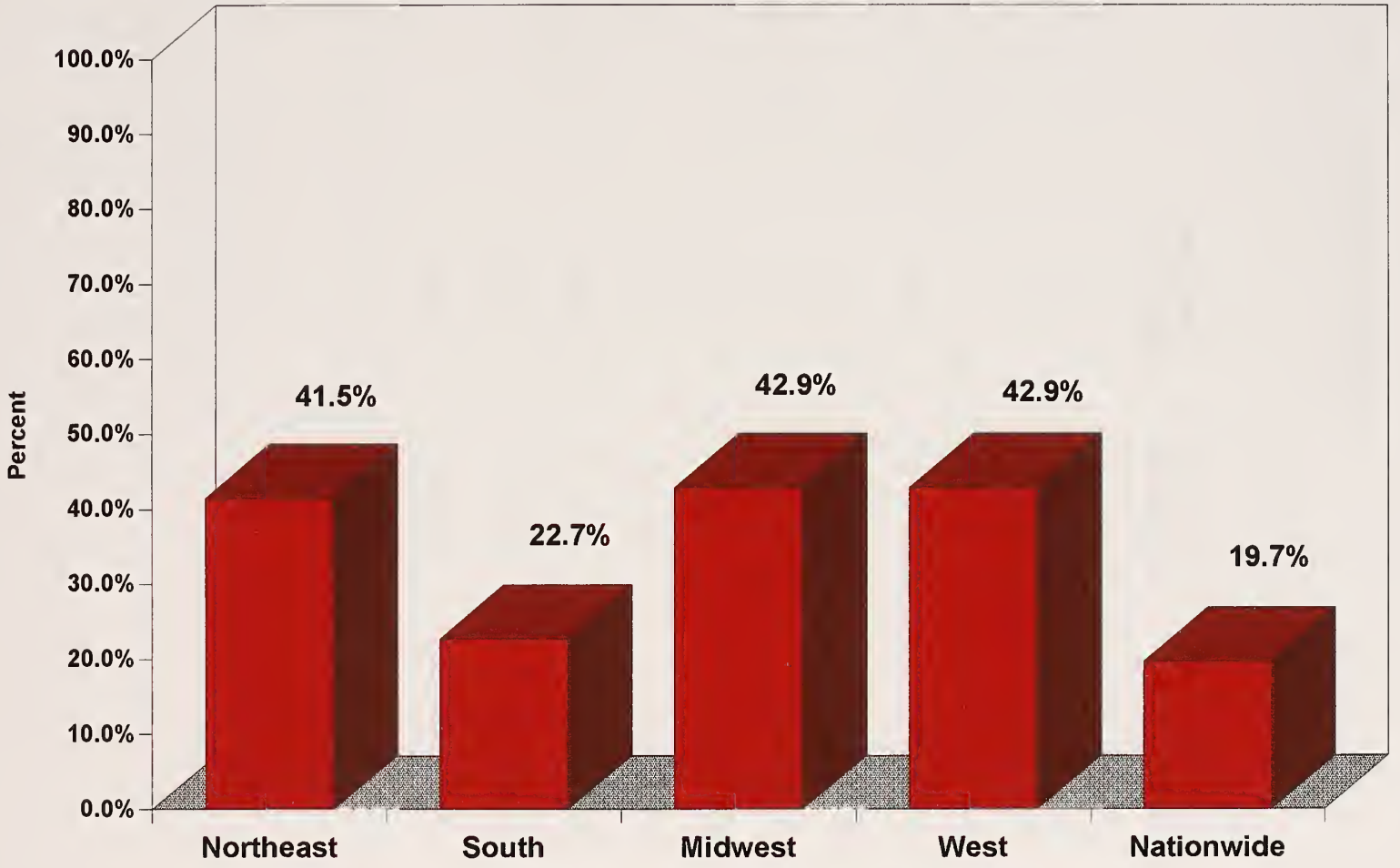
EXHIBIT 9
PERCENT OF PAYERS ADOPTING RBRVS BY GEOGRAPHIC COVERAGE AREA



n = 111

Source: Deloitte &Touche, Boston, MA, 1993

EXHIBIT 10
PERCENT OF RESPONDENTS IN EACH REGION ADOPTING RBRVS



n = 111
One respondent is not from the continental U.S.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 11
ORGANIZATIONAL SIZE OF PAYERS IN SAMPLE: PHYSICIANS, ENROLLEES AND EXPENDITURES

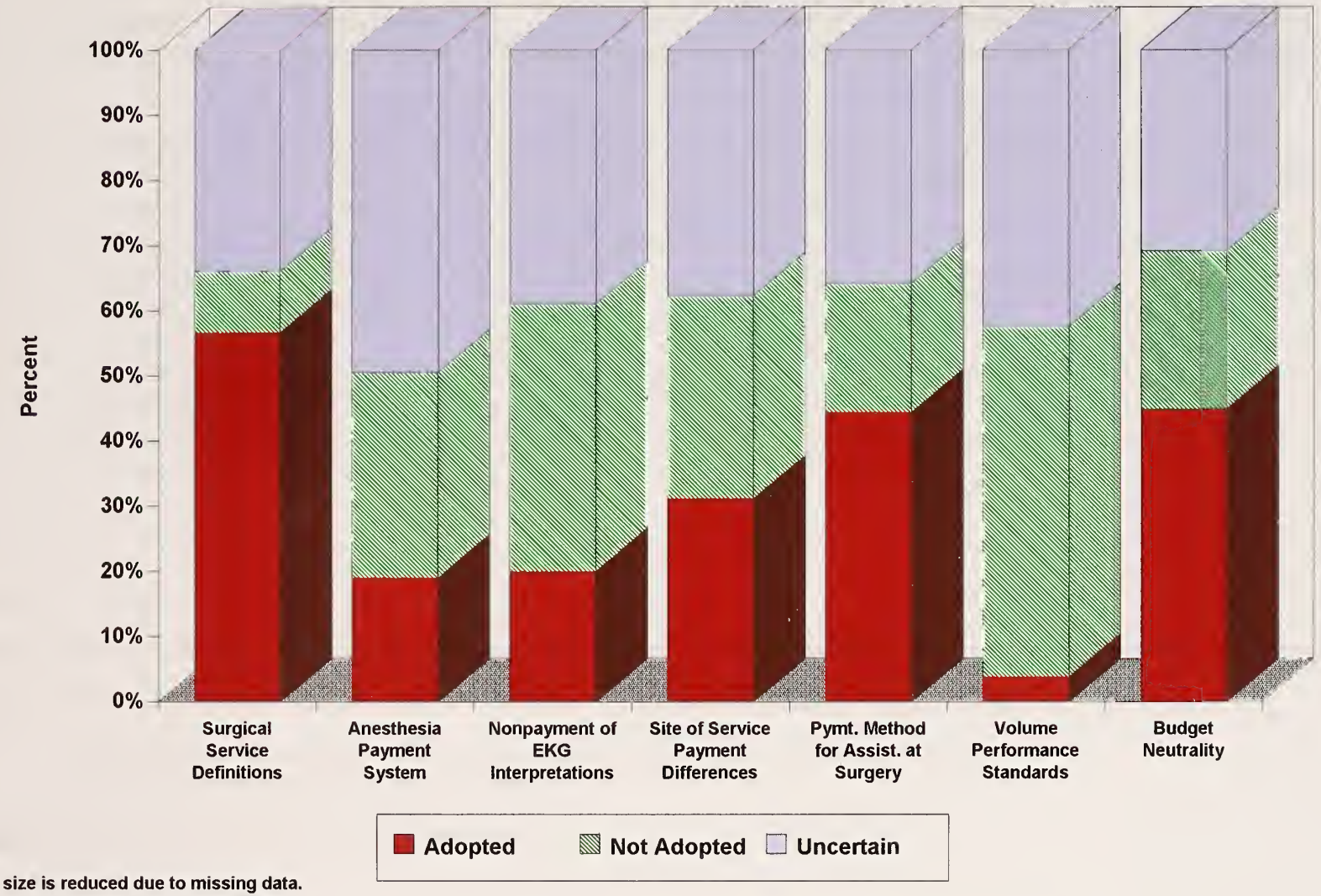
Payer Type	Mean Number of Physicians	Mean Number of Enrollees	Mean Expenditures on Physician Services *
Adopters	7,489	549,774	$142,821,546
Non-Adopters	9,977	157,246	$45,980,320
State Medicaid Programs	7,438	449,811	$101,523,079
Indemnity Insurers	29,107	383,121	$157,198,531
Blue Cross/Blue Shield Organizations	8,099	825,614	$215,126,420
HMO - IPA Models	2,429	201,992	$54,123,955
HMO - Staff/Group Models	2,149	65,640	$25,135,097
Preferred Provider Organizations	7,598	680,237	$63,683,508
Third Party Administrators	9,910	111,640	$35,674,216
Self-Insured Corporations	16,475	66,056	$42,584,524

* 1992 Dollars.

Note: The following outliers were trimmed from the dataset:
1) Number of physicians less than 50 or greater than 200,000.
2) Number of enrollees less than 1,000.
3) Physician expenditures less than 100,000 or greater than one billion.

Source: Deloitte & Touche Survey, 1993.

EXHIBIT 12
MEDICARE PAYMENT POLICIES ADOPTED BY ALL PAYERS



n = 106
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 13
EXTENT TO WHICH STATE MEDICAID PROGRAMS HAVE EMBRACED RBRVS

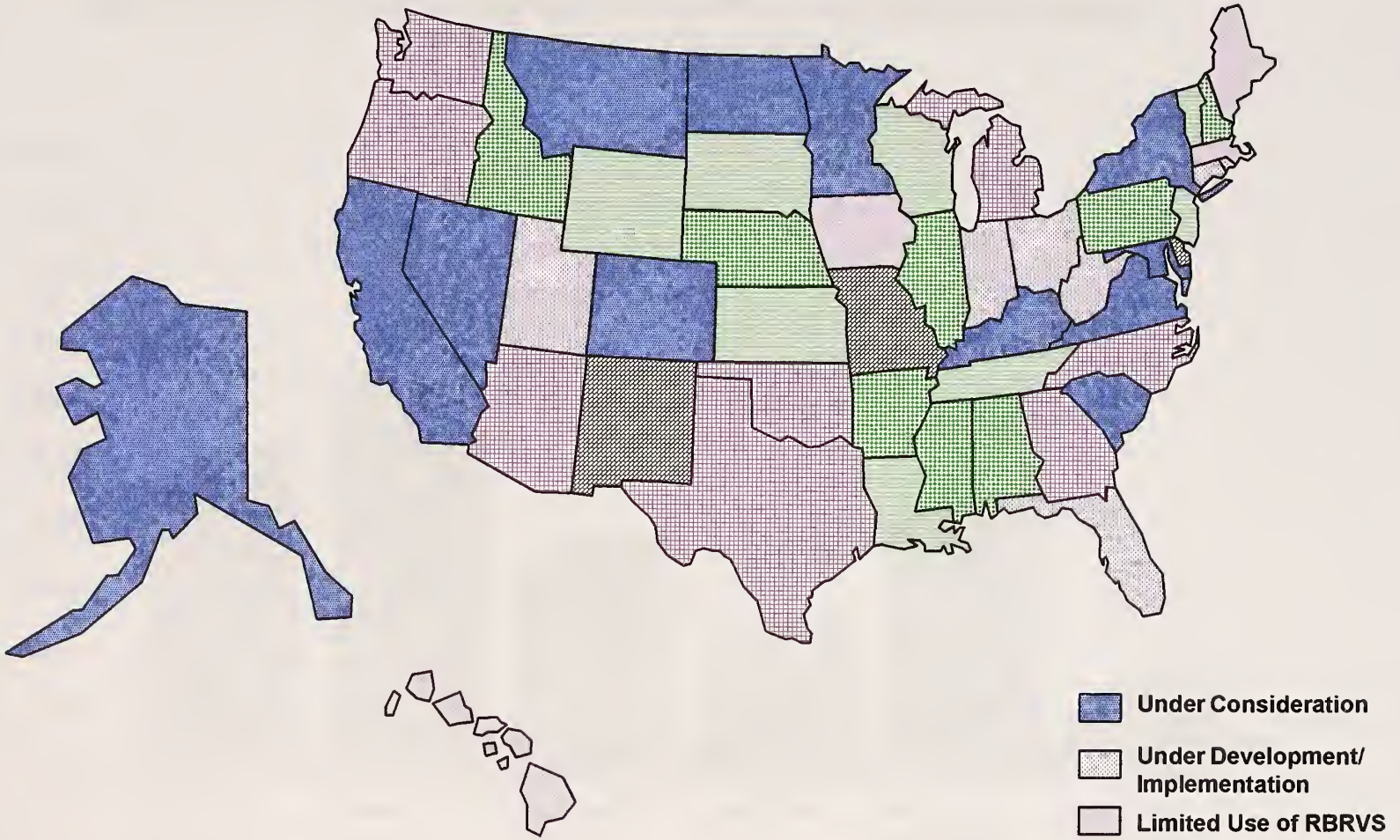
Under Consideration	Under Development/ Implementation	Implemented	Decided Not To Adopt	Have Not Considered	Limited Use of RBRVS
Alaska	Connecticut	Arizona*	Kansas	Alabama	Hawaii
California	Florida	Georgia	Louisiana	Arkansas	Iowa
Colorado	Indiana	Michigan	New Jersey	District of Columbia	Massachusetts
Kentucky	Ohio	North Carolina	South Dakota	Idaho	Maine
Maryland	Rhode Island	Oklahoma	Tennessee	Illinois	
Minnesota	Utah	Oregon	Vermont	Mississippi	
Montana	West Virginia	Texas	Wisconsin	Nebraska	
Nevada		Washington	Wyoming	New Hampshire	
New York				Pennsylvania	
North Dakota					
South Carolina					
Virginia					
Total	12	7	8	8	9	4	= 48

Note: Missouri, Delaware, and New Mexico were non-respondents. Puerto Rico and U.S. Virgin Islands were not included in the sample.

* Most of Arizona'a Medicaid enrollees are in managed care plans. Therefore, RBRVS will apply only to those Medicaid recipients temporarily outside of a managed care network.

Source: Deloitte & Touche Original and Follow-up Surveys, 1993.

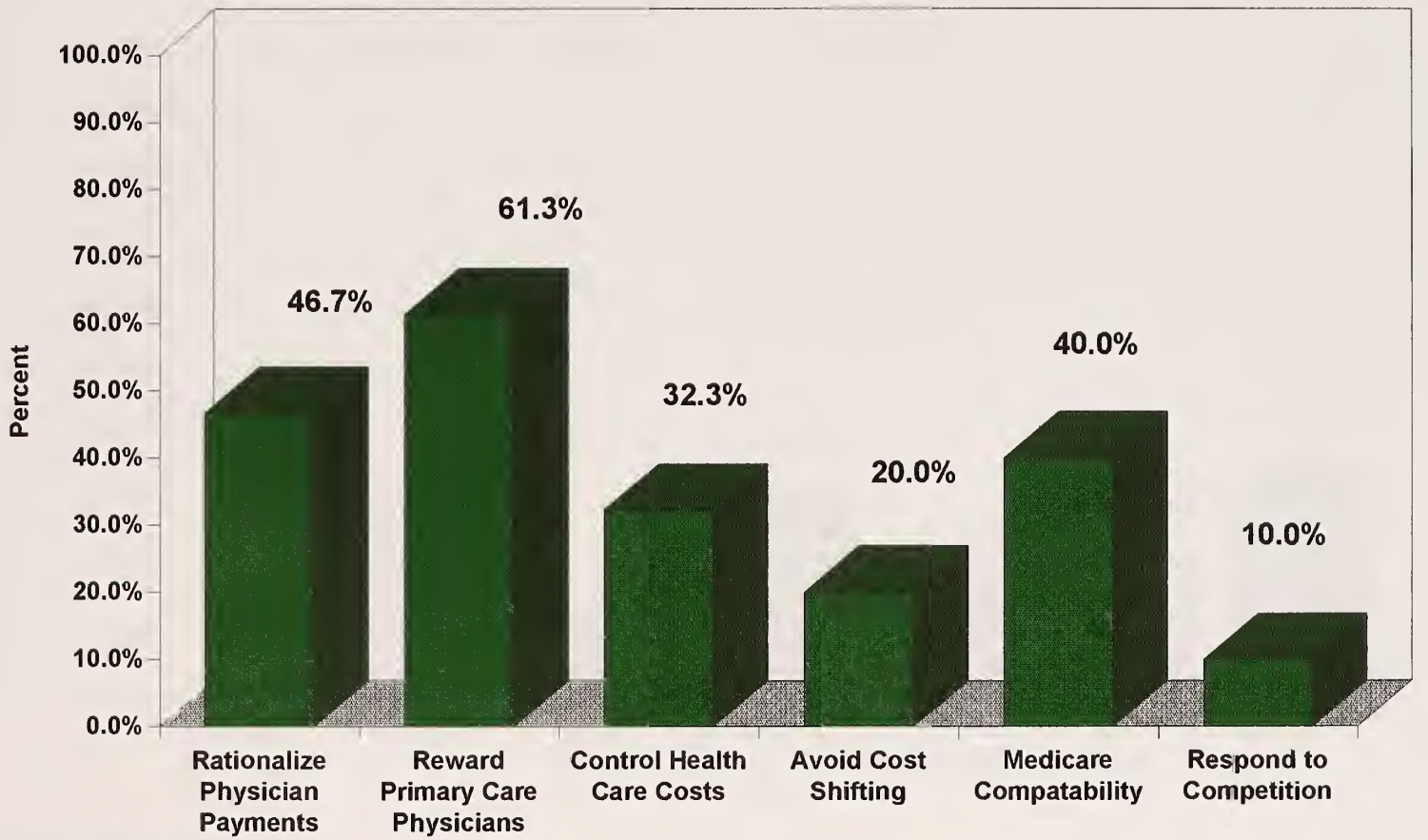
EXHIBIT 14
IMPLEMENTATION STATUS OF RBRVS: STATE MEDICAID PROGRAMS



Note: Missouri, Delaware, and New Mexico were non-respondents.
Puerto Rico and U.S. Virgin Islands were not included in the sample.

Source: Deloitte & Touche Original and Follow-up Surveys, 1993.

EXHIBIT 15
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: STATE MEDICAID PROGRAMS

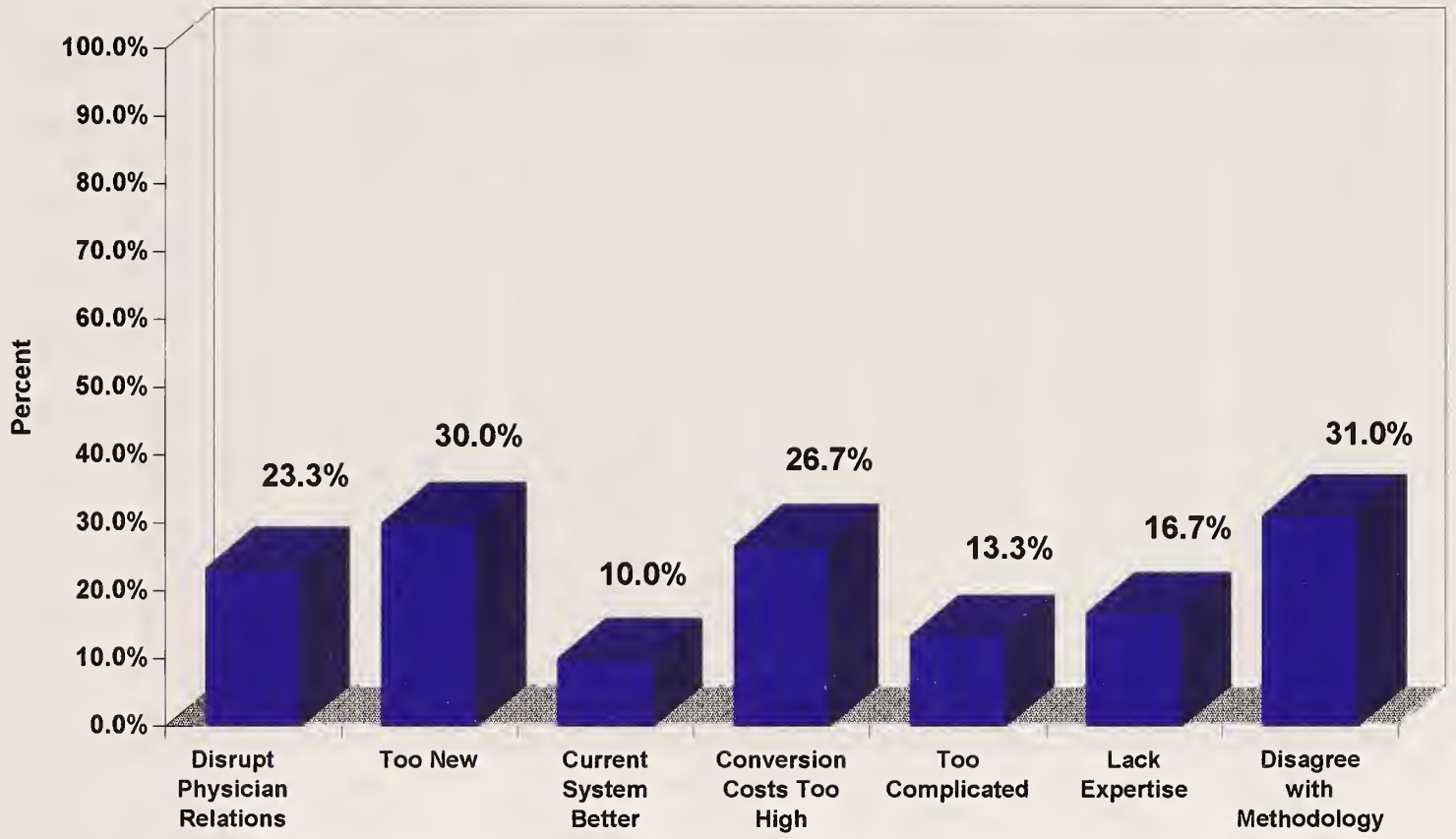


n=32

Sample size is reduced due to missing data.

Source: Deloitte & Touche Survey, 1993.

EXHIBIT 16
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: STATE MEDICAID PROGRAMS

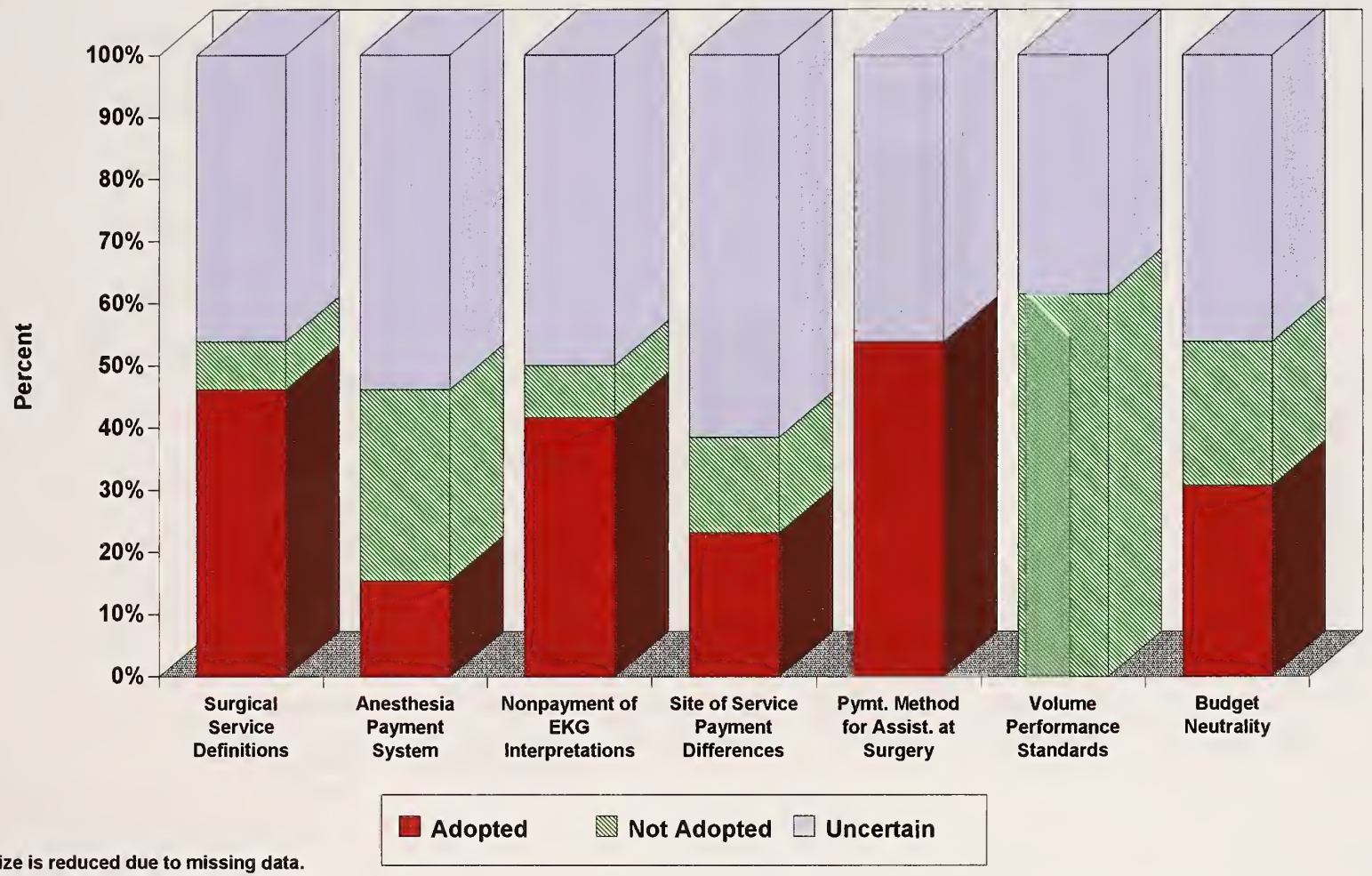


n=32

Sample size is reduced due to missing data.

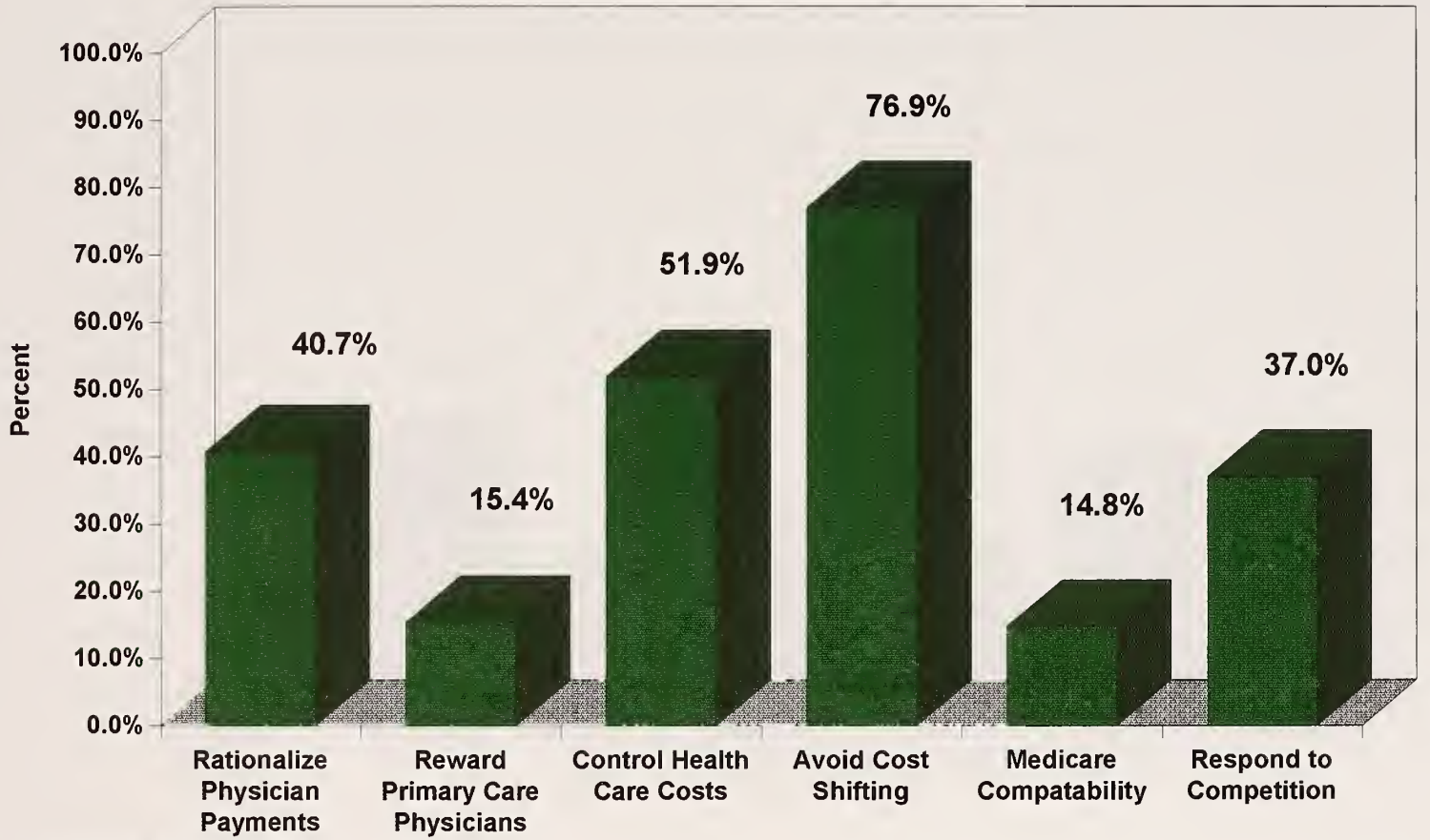
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 17
MEDICARE PAYMENT POLICIES ADOPTED BY STATE MEDICAID PROGRAMS



n = 13
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 18
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: INDEMNITY INSURERS

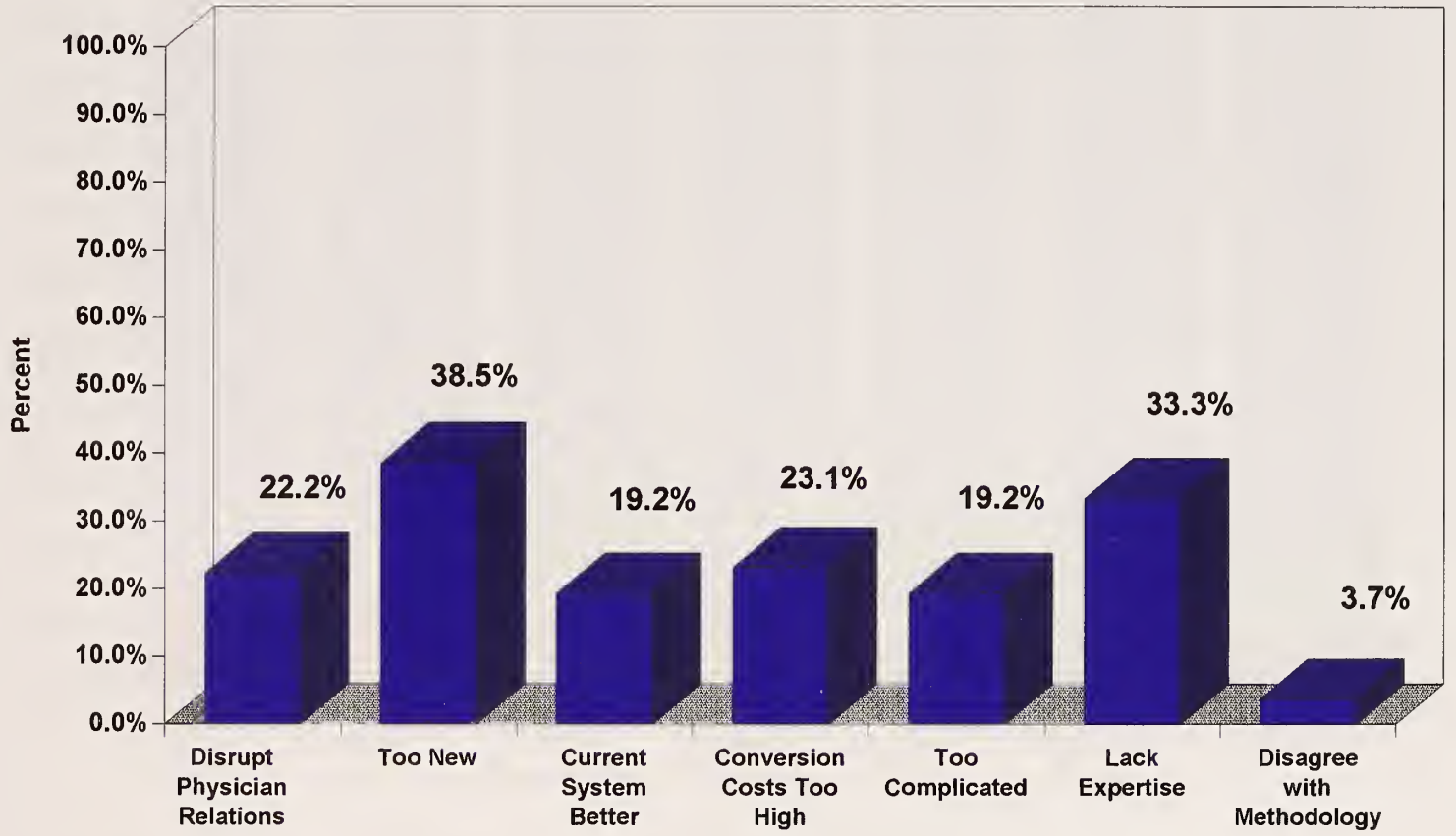


n = 27

Sample size is reduced due to missing data.

Source: Deloitte & Touche Survey, 1993.

EXHIBIT 19
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: INDEMNITY INSURERS

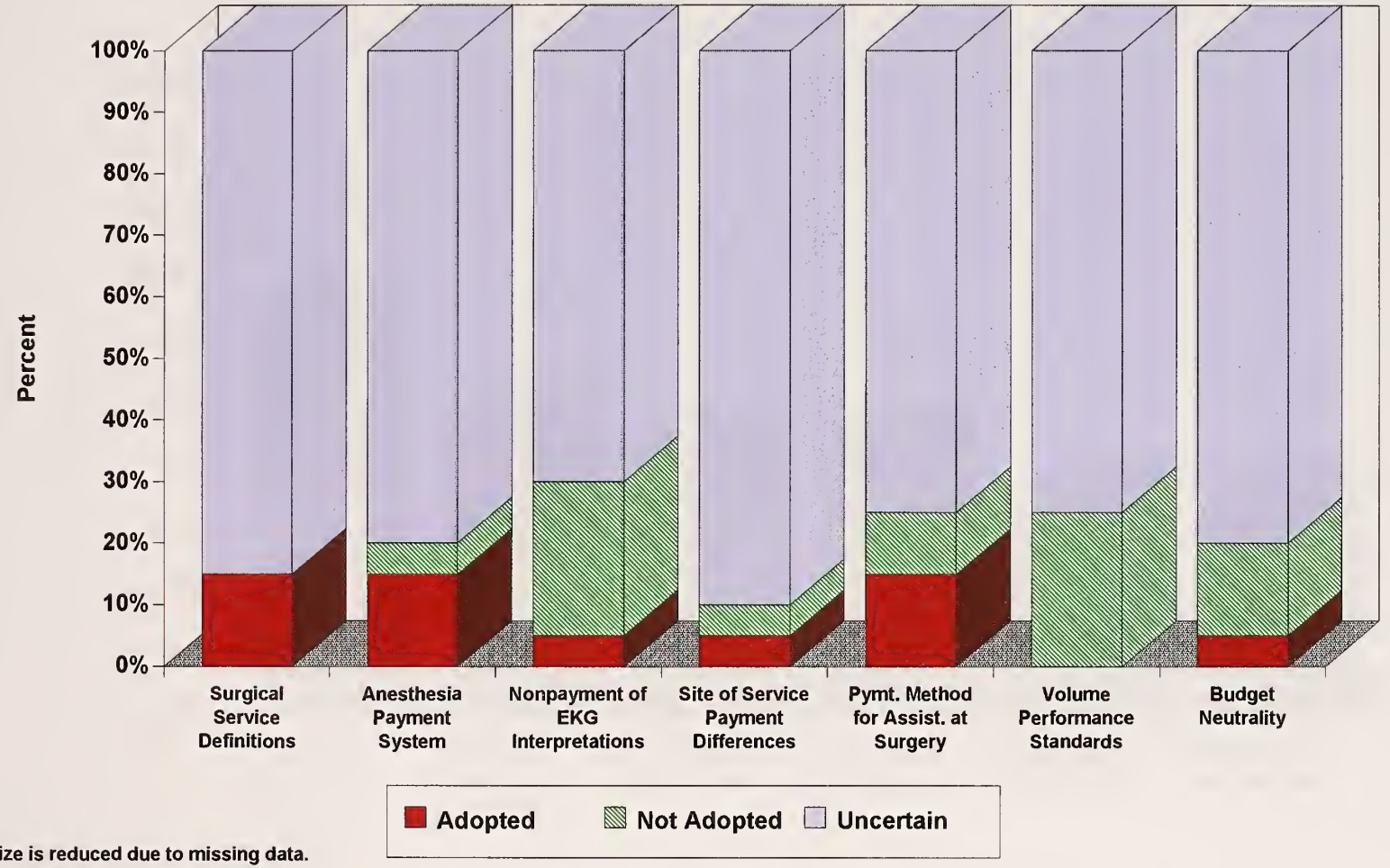


n=27

Sample size is reduced due to missing data.

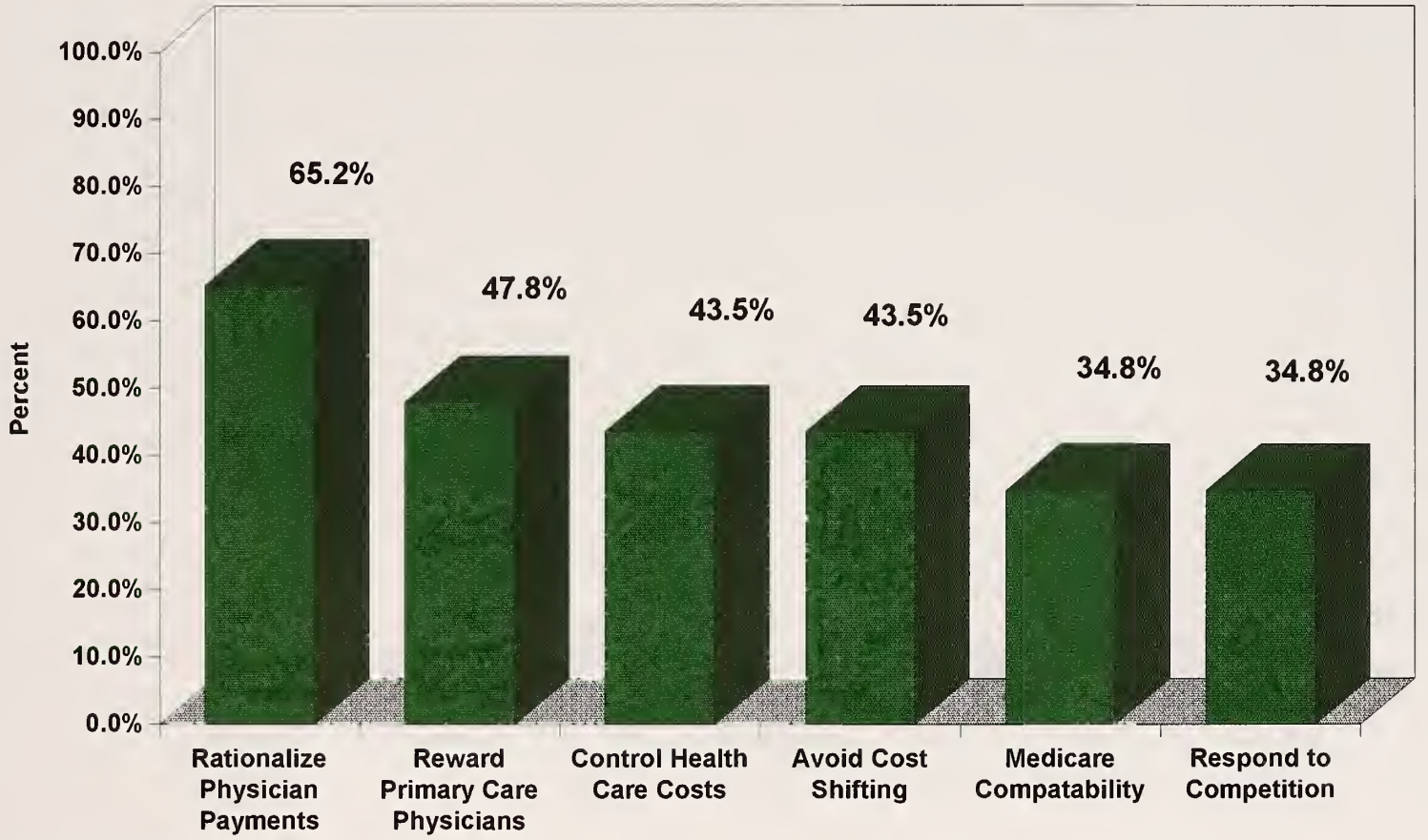
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 20
MEDICARE PAYMENT POLICIES ADOPTED BY INDEMNITY INSURERS



n = 20
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

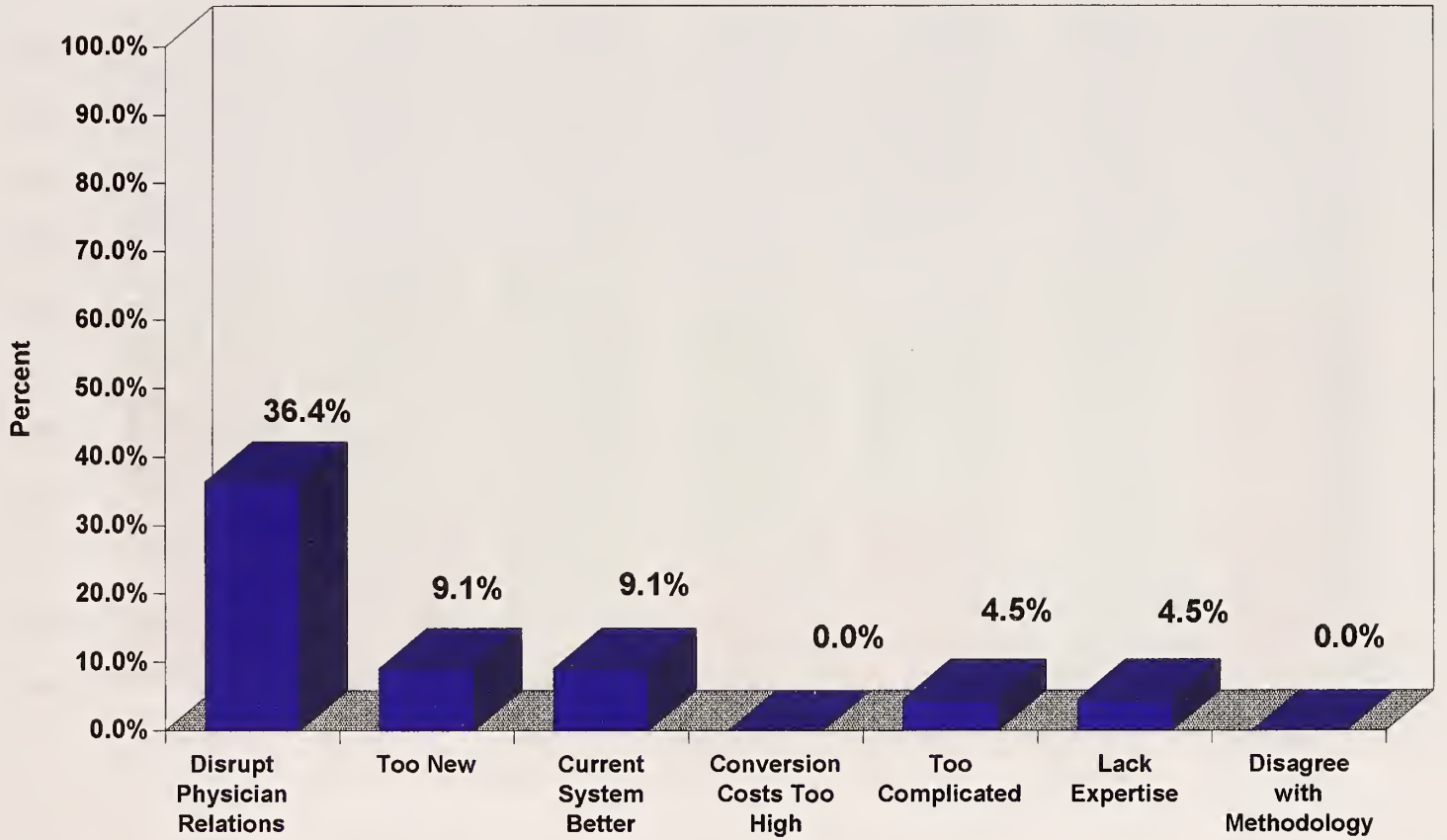
EXHIBIT 21
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: BLUE CROSS/BLUE SHIELD INSURERS



n=24

Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

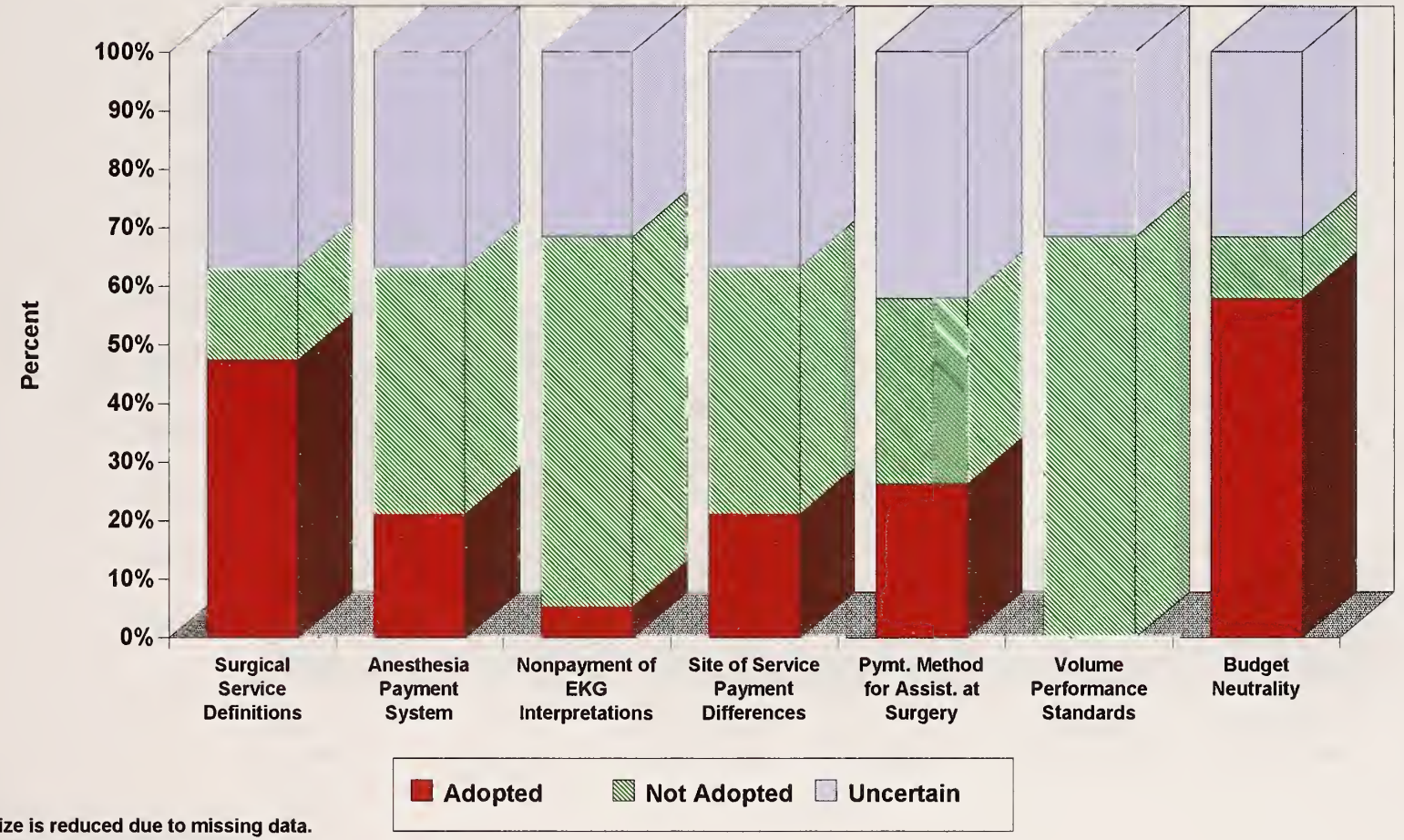
EXHIBIT 22
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: BLUE CROSS/BLUE SHIELD INSURERS



n=24

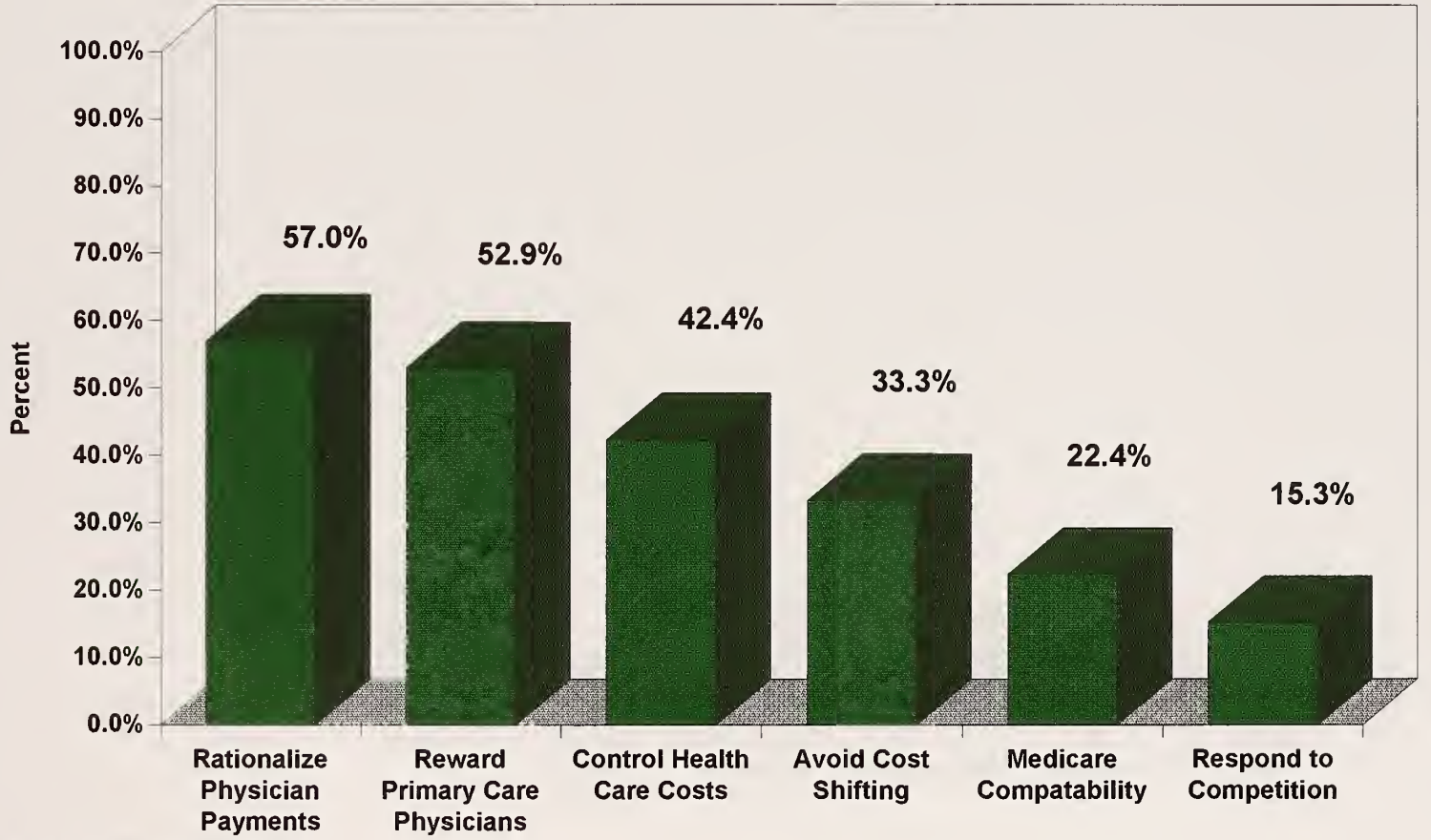
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 23
MEDICARE PAYMENT POLICIES ADOPTED BY BLUE CROSS/BLUE SHIELD INSURERS



n = 19
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 24
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: HMO - IPA MODELS

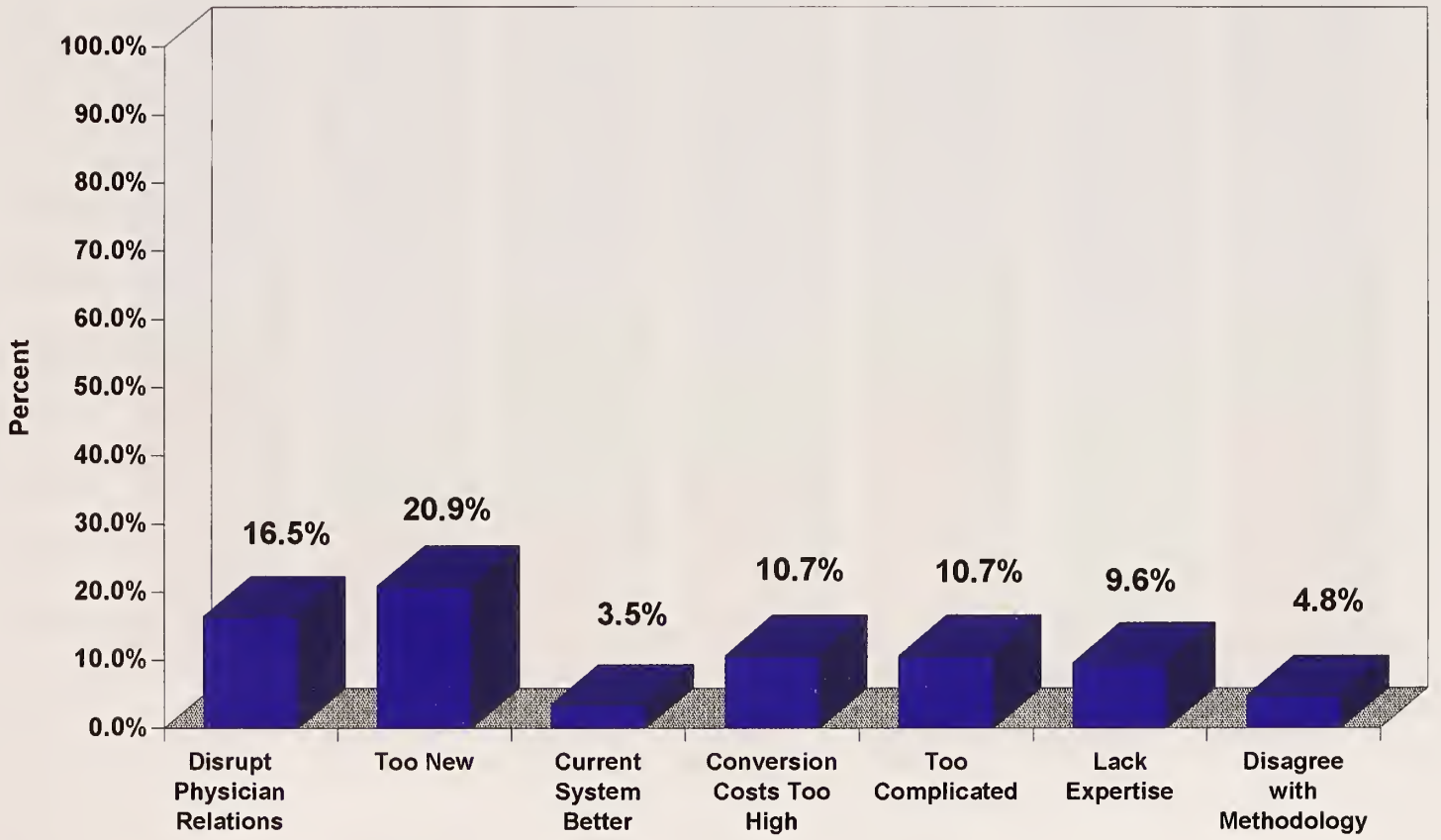


n=87

Sample size is reduced due to missing data.

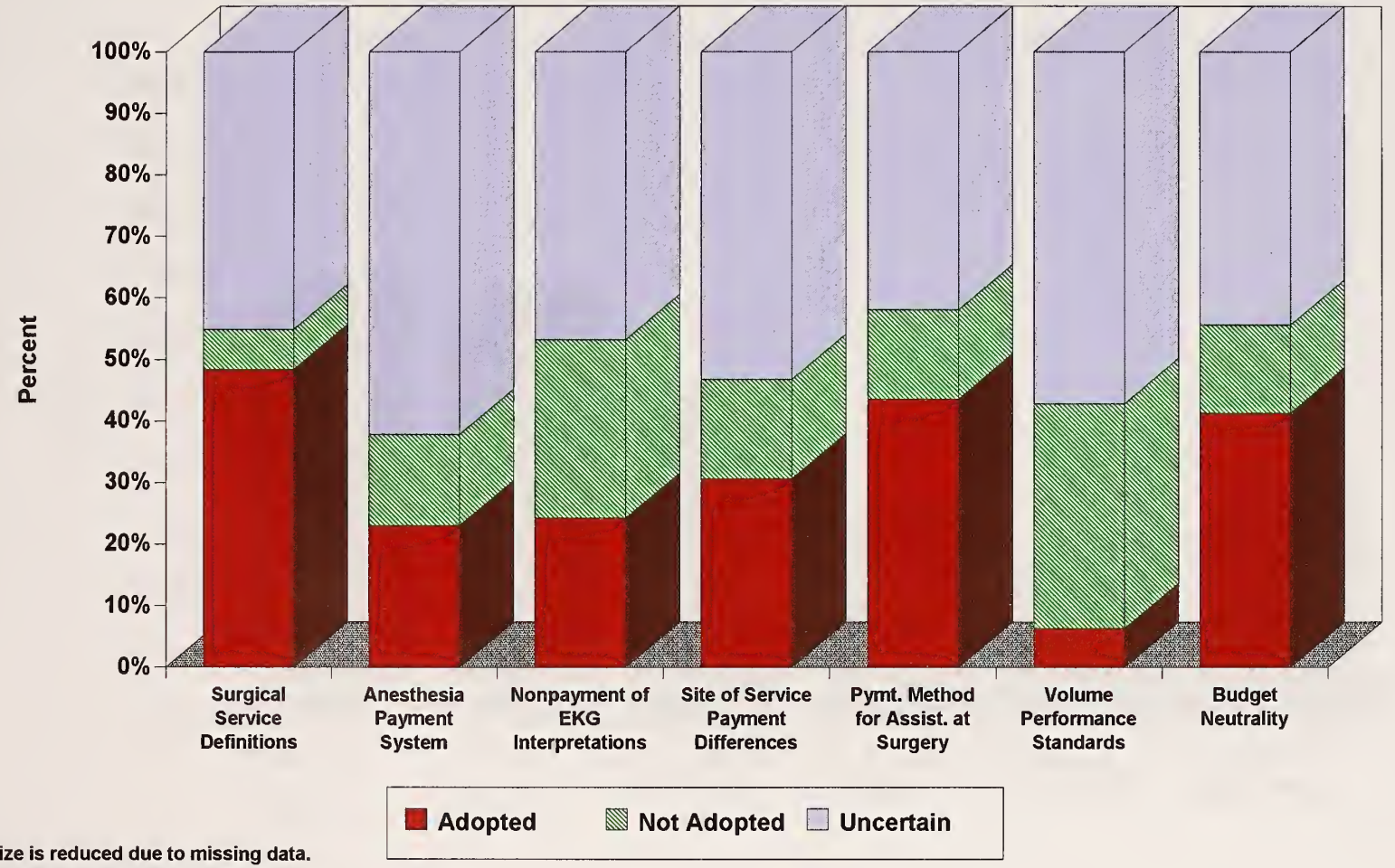
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 25
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: HMO - IPA MODELS



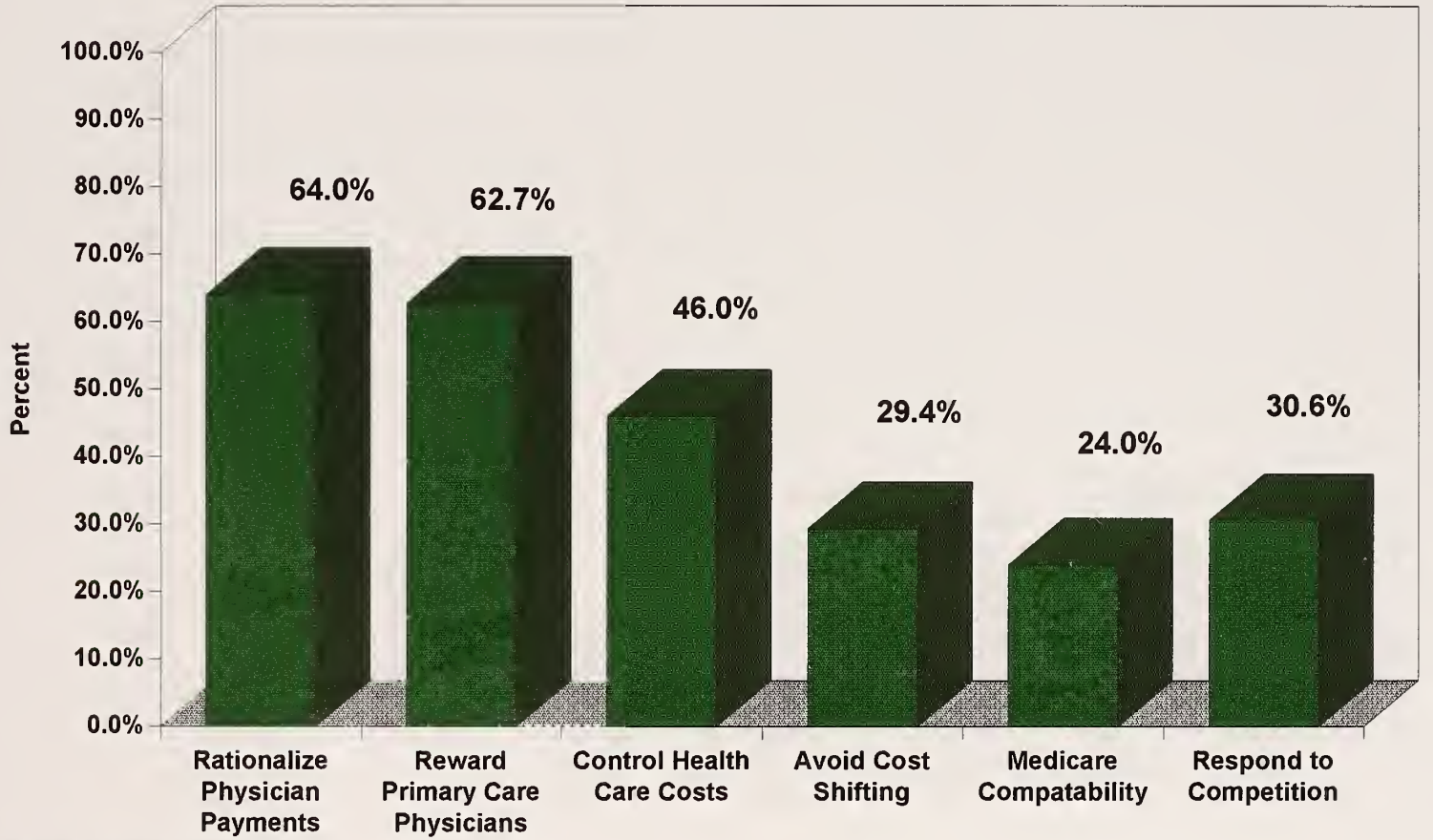
n=87
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 26
MEDICARE PAYMENT POLICIES ADOPTED BY HMO - IPA MODELS



n = 62
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 27
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: PREFERRED PROVIDER ORGANIZATIONS

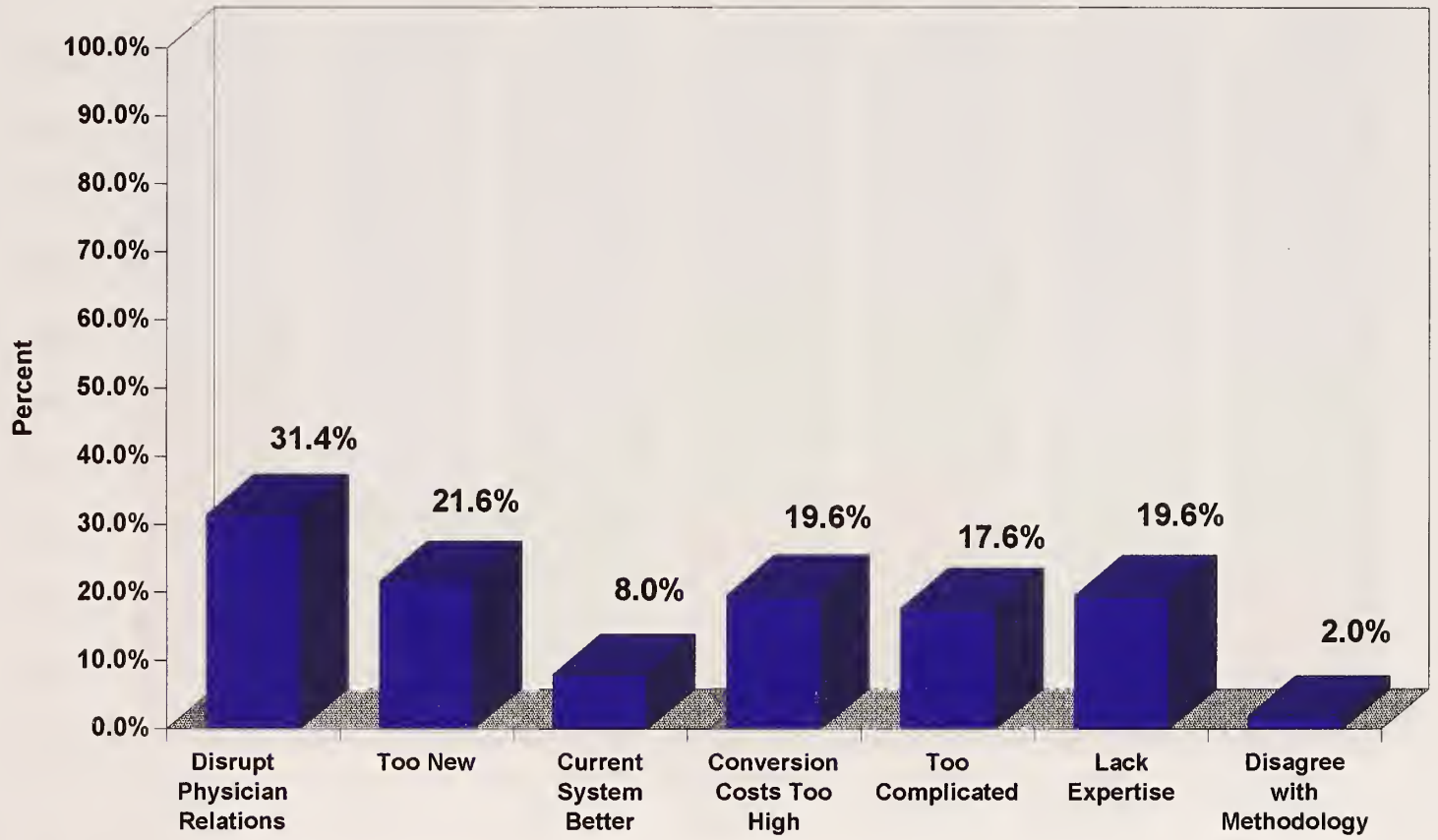


n=51

Sample size is reduced due to missing data.

Source: Deloitte & Touche Survey, 1993.

EXHIBIT 28
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: PREFERRED PROVIDER ORGANIZATIONS

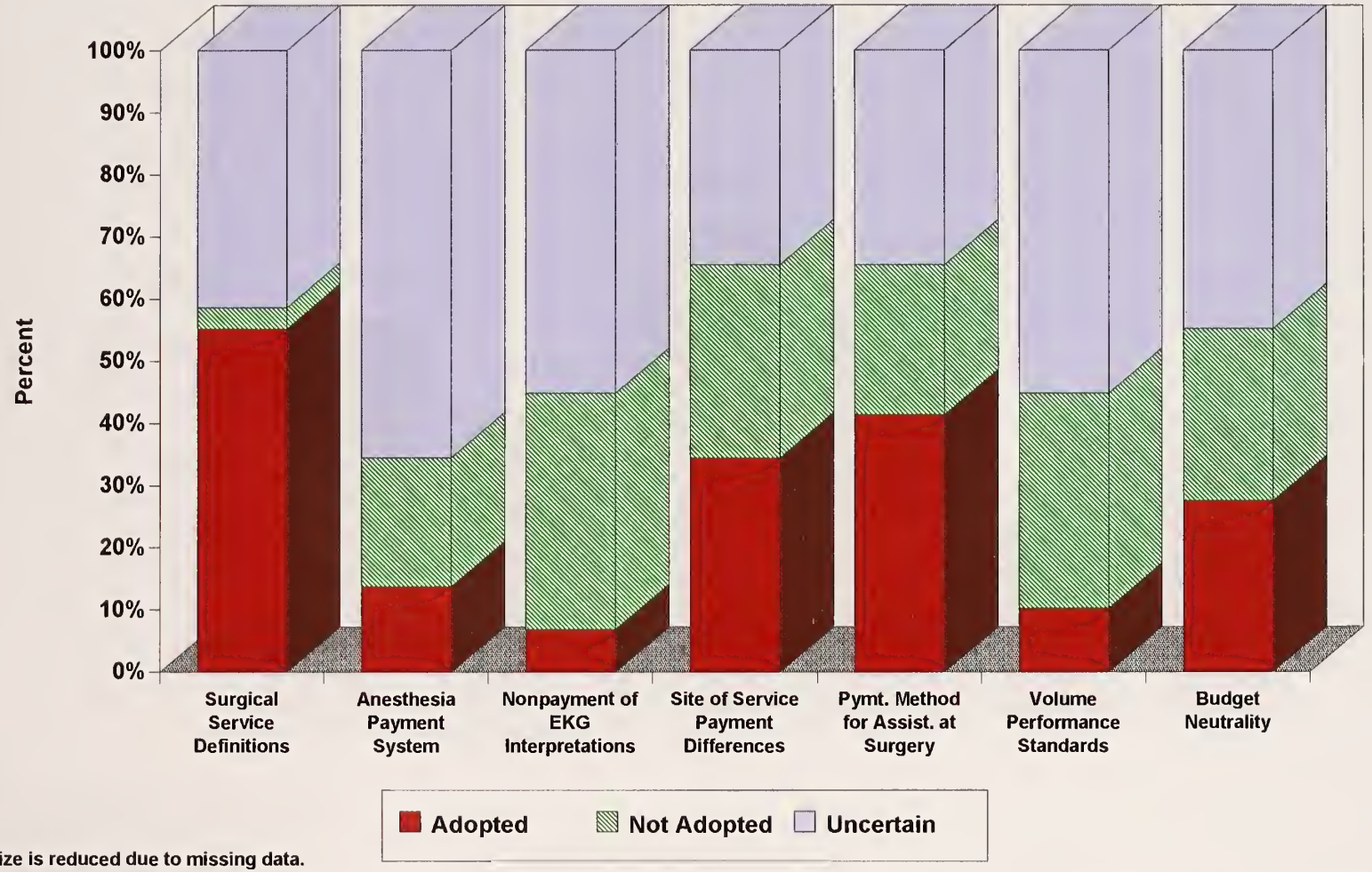


n=51

Sample size is reduced due to missing data.

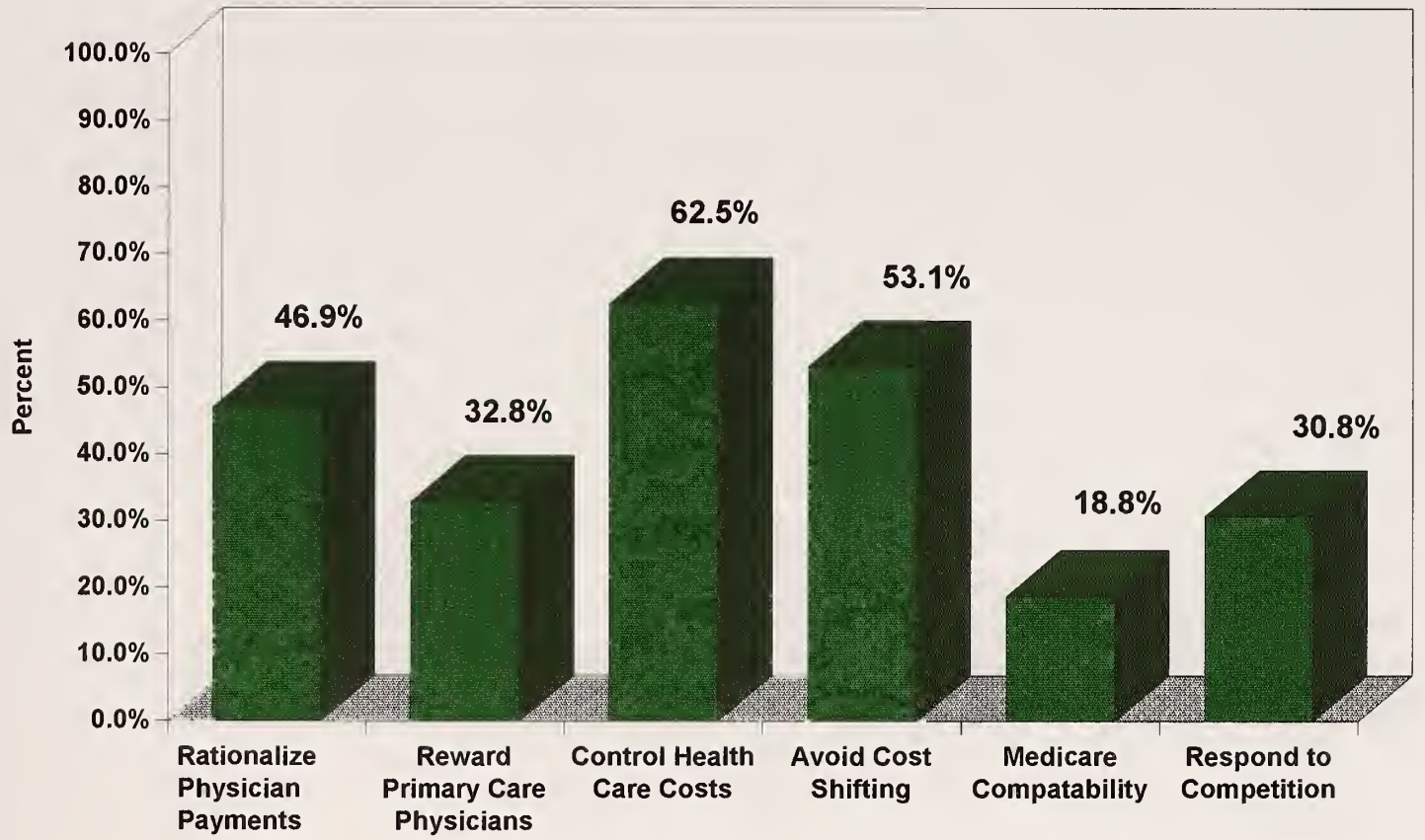
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 29
MEDICARE PAYMENT POLICIES ADOPTED BY PREFERRED PROVIDER ORGANIZATIONS



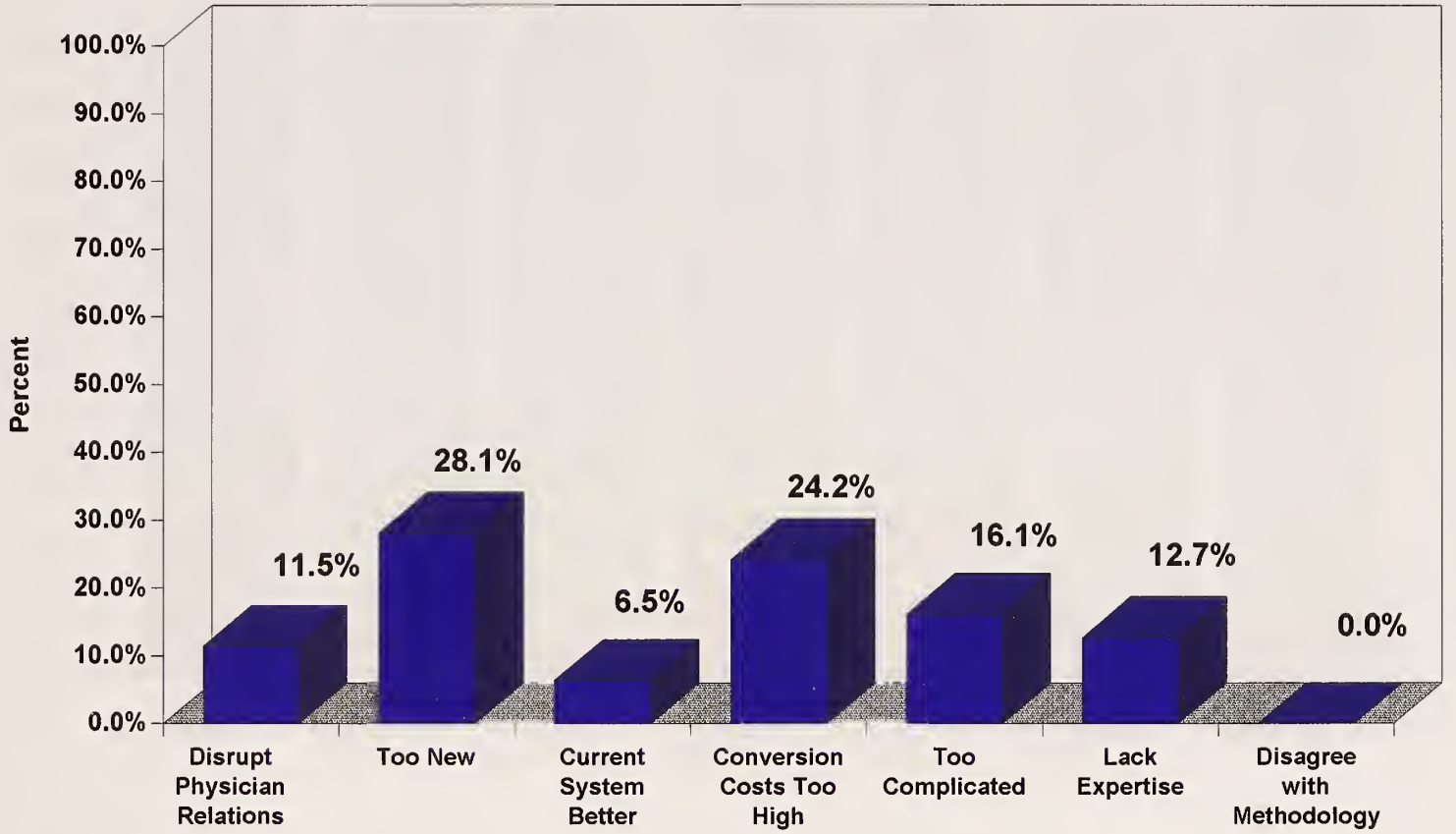
n = 29
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 30
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: THIRD PARTY ADMINISTRATORS



n=68
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

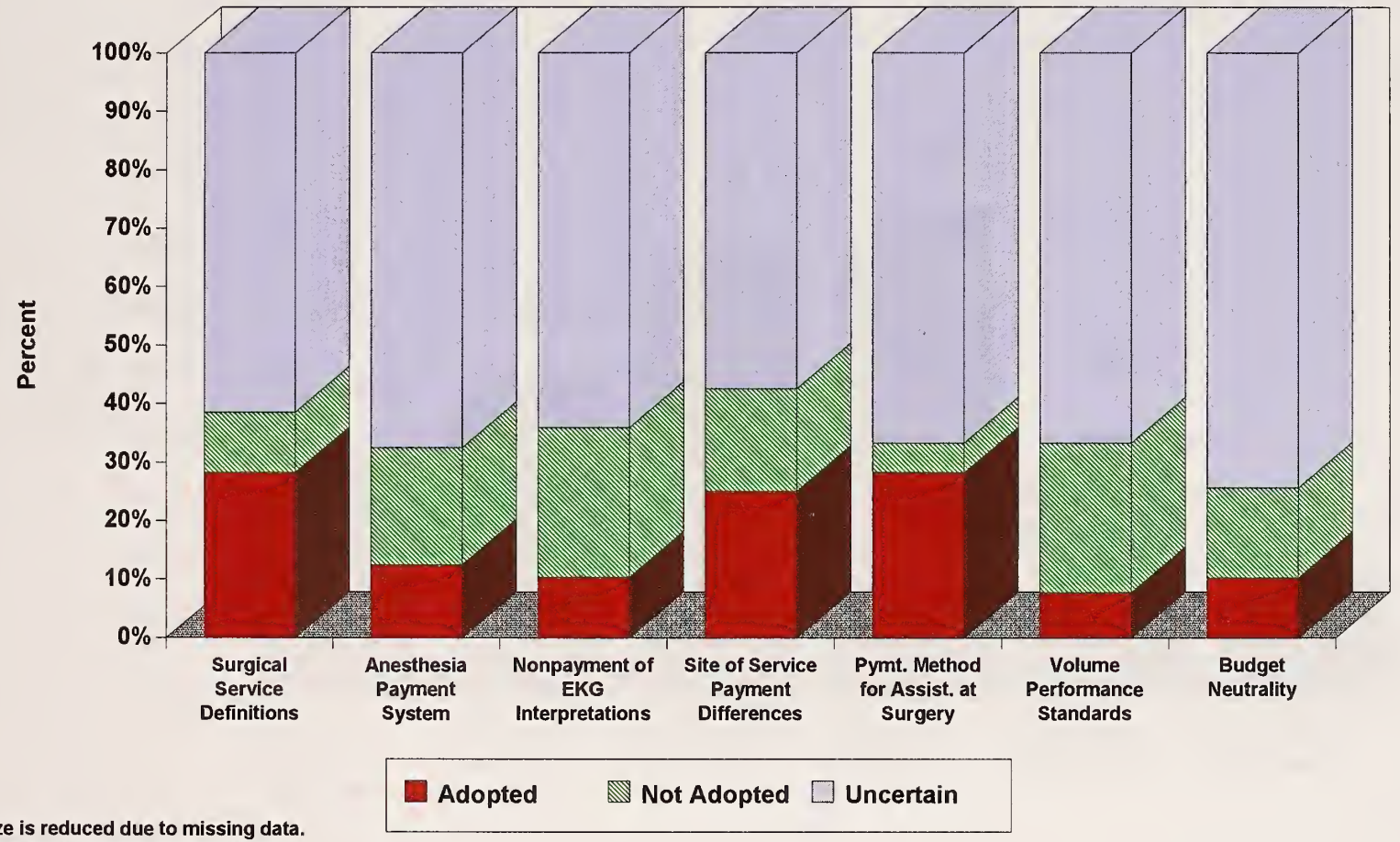
EXHIBIT 31
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: THIRD PARTY ADMINISTRATORS



n=68

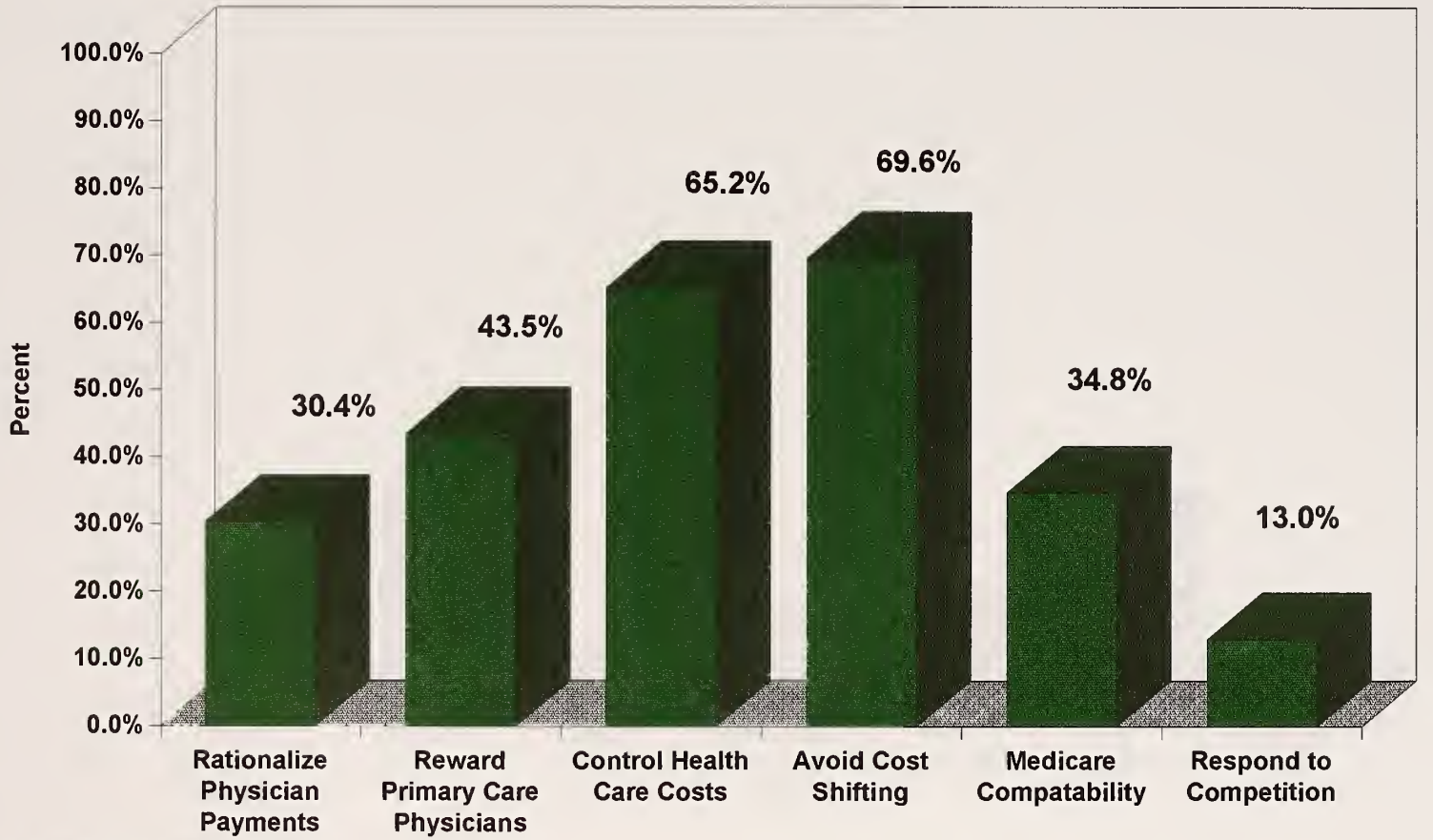
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 32
MEDICARE PAYMENT POLICIES ADOPTED BY THIRD PARTY ADMINISTRATORS



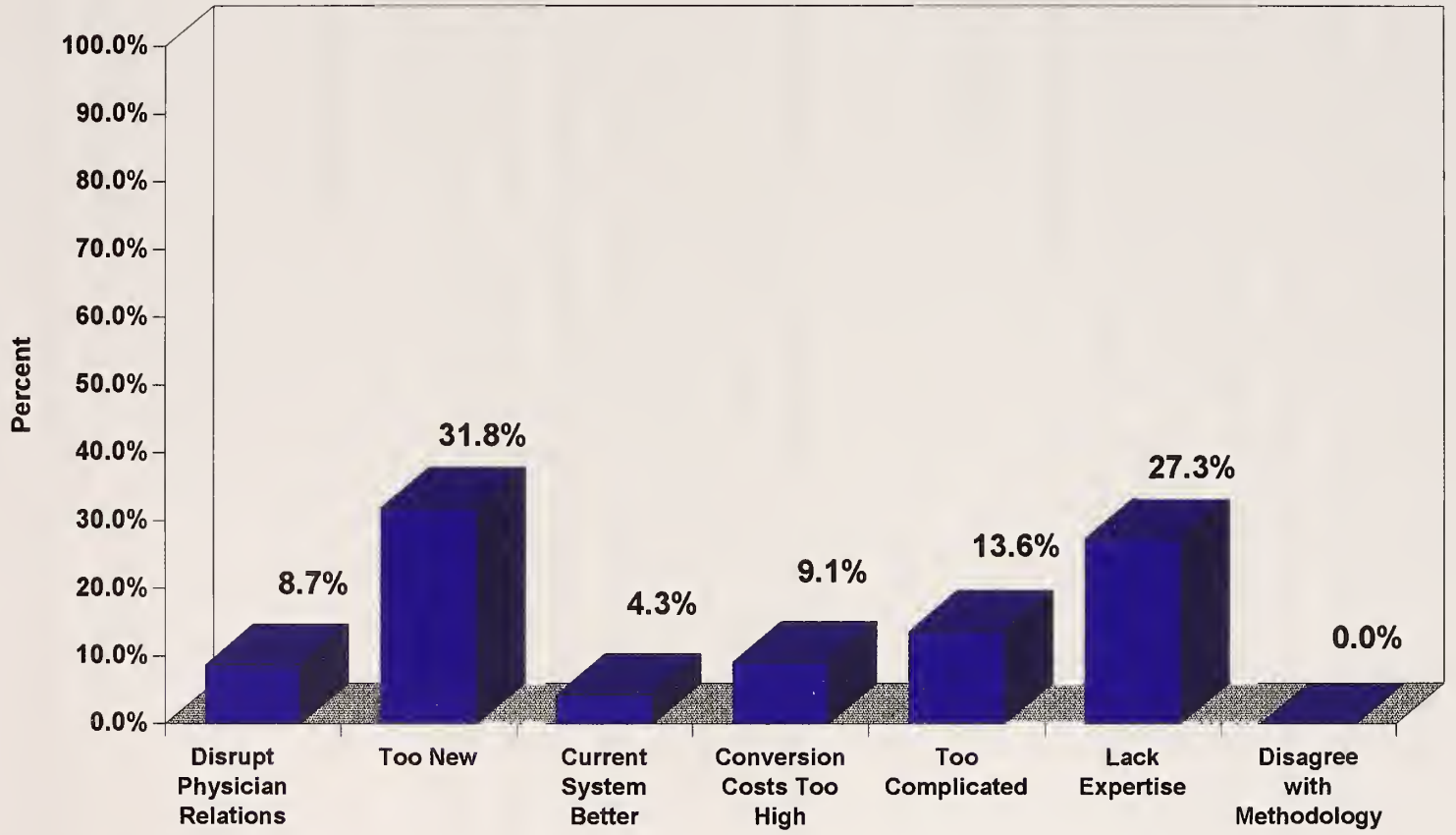
n = 40
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 33
BENEFITS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: SELF-INSURED CORPORATIONS



n=24
Sample size is reduced due to missing data.
Source: Deloitte & Touche Survey, 1993.

EXHIBIT 34
DRAWBACKS OF RBRVS CONSIDERED TO BE OF HIGH IMPORTANCE: SELF-INSURED CORPORATIONS



n=24

Sample size is reduced due to missing data.

Source: Deloitte & Touche Survey, 1993.

4.0 CASE STUDY FINDINGS

This section contains twelve individual case study reports. Each section is a "stand alone" document and contains detailed, in-depth information about payers' payment program characteristics, the development of their RBRVS fee schedules, and a descriptive summary of their payment policies and billing practices. Section 4.1 includes reports for three state Medicaid programs. Two workers' compensation program case studies are found in Section 4.2. A case study of CHAMPUS, the national program which pays for health care provided to military beneficiaries in the private sector, is found in Section 4.3. Finally, case studies of six private payers are contained in Sections 4.4 and 4.5. A synthesis of the case studies is found in Section 4.6 while Exhibits 35, 36, 37, and 38 summarize key technical aspects and policy components of payers' payment programs.

4.1 State Medicaid Programs

4.1.1 Washington

4.1.1.1 Background

The Medicaid program, run by the Medical Assistance Administration, had annual expenses for physician services of about $137.3 million in Fiscal Year 1992 and is the state's largest purchaser of health care.[1] Nearly 500,000 people are eligible to receive Medicaid benefits. As a result of escalating program expenditures (16% growth in FY 1991), and physician expenditures in particular, Medicaid joined forces with the State Health Care Authority (HCA) and the Department of Labor & Industries workers' compensation program in adopting an RBRVS-like fee schedule. Prior to its RBRVS adoption, Washington Medicaid reimbursed physicians on a usual, customary and reasonable (UCR) charge basis using the Washington Relative Value Scale.[2]

4.1.1.2 RBRVS Implementation

Development

[1] Source: HER calculations using HCFA 2082 data, 1992.

[2] The Washington RVS is based on the California RVS, which is charge based. The state of Washington made adjustments to the California RVS over time as needed.

The genesis for adopting RBRVS by the three state health care payors was a 1990 study, Study of State Purchased Health Care, commissioned by the Washington State Legislature through the HCA. The study produced estimates of total health care expenditures--in terms of delivery, purchasing, funding, and regulation of health care providers--for the public payors in the state of Washington. The study also showed that opportunities to ameliorate current health care purchasing existed and could be realized by greater coordination and program uniformity among the three payors.

Recommendations from this study led to the release of a Request For Proposal (RFP) in January 1992 to develop RBRVS fee schedules for program implementation. Specific goals for implementing RBRVS fee schedules included:

- Developing a common system of fees with prospective fees based on resource costs of providing services;
- Forming a powerful health care purchasing alliance to affect incentives for delivering health care (e.g., more primary care vis-a-vis procedure-oriented services, improved access to care);
- Reduce administrative costs imposed on providers by standardizing and streamlining reporting requirements.

The goals set for RBRVS reflect Medicaid's expectations and perceptions regarding the RBRVS methodology. Major concerns about RBRVS held by Medicaid included the applicability of RVUs for obstetrical care codes, preventive medicine codes, pediatric codes, and maternity codes.

The most extraordinary aspect of the RBRVS development process was the overall degree and extent of interagency coordination. HCA was appointed by the state legislature to serve as "project manager" of the RBRVS fee schedule implementation for all three agencies. A 12-member RBRVS Steering Committee (RSC) was created from key personnel at each agency. The RSC met weekly and was charged with making policy decisions and coordinating development and implementation of the RBRVS fee schedules.

The three state programs understood that health care providers must be involved in the development of any viable RBRVS fee schedule. This key insight led to the assembling of the provider Technical Advisory Group (TAG) made up of representatives from state health care

associations.[3] The TAG met monthly and was co-chaired by HCA's Medical Director and the RBRVS project manager. In broad terms, the TAG's purpose was to:

- obtain policy and technical input from providers and groups affected by the switch to RBRVS,
- inform all parties affected by the move to RBRVS on the project's development and decisions, and
- provide advice to the project team on technical matters (e.g., payment for procedures without Medicare RVUs, transition approach for implementation of RBRVS, etc.) and policy issues (e.g., site of service adjustments, use of Medicare's global surgery payment rules, etc.).

The combined efforts of the RSC and TAG were essential in shaping the final program design for each payor.

Program Design

Medicaid's physician payment system uses an RBRVS fee schedule which was implemented on January 1, 1993. Medicare's fee schedule was not adopted "wholesale," but most Medicare RVUs and many Medicare payment policies are being used by Washington Medicaid.

The final payment system is one based on Medicare RVUs and imputed RVUs, does not employ Medicare GPCIs, and uses four distinct conversion factors under budget neutrality constraints.

RVUs, GPCIs and Conversion Factors

Medicaid and HCA implemented RBRVS fee schedules using 1992 Medicare RVUs.[4] Procedure codes without Medicare RVUs--for example, preventive, newborn, team conference, telephone call, after hours services--were assigned imputed RVUs.[5] Medicaid decided to

[3]The associations represented on the TAG included the following: Certified Registered Nurse Anesthesiologists; Chiropractic Association; Licensed Midwives; Medical Association; Medical Group Managers' Association; Nurses' Association; Nurse Midwives; Optometric Association; Osteopathic Medical Association; Physical Therapy Association; Podiatry Association; Psychological Association.

[4]Labor and Industries (workers' compensation) was unable to implement its RBRVS fee schedule on 1-1-93 because it was required to go through a legislative approval process, thus causing delays. Implementation was scheduled for September 1, 1993.

[5]Only the top 300 procedures without Medicare RVUs, by frequency, were assigned imputed state-specific RVUs.

maintain its 1992 fees for obstetrical codes rather than use Medicare RVUs to determine fees because it did not believe obstetric RVUs were adequate or appropriate. On July 1, 1993, Medicaid and HCA updated their RVUs to Medicare 1993 RVUs. Future RVU updates will continue to be based on Medicare RVU updates.

The three agencies agreed to use a common coding system. Prior to calculation of conversion factors, each payor was using its own local codes and not all were using HCPCS Level II codes (though all were using CPT codes). The programs agreed to use CPT codes and HCPCS Level II codes, and to eliminate payor-specific local codes and replace them with common local codes across all payors.

Because of significant differences between the three agencies in terms of benefit packages, policies, population served, and medical requirements for beneficiaries, it was decided that each program would develop and maintain its own unique conversion factor.[6] Within the Medicaid program, four distinct conversion factors were created under budget neutrality constraints based on 1991 Medicaid claims data: Maternity Services ($49.02); Pediatric Services ($38.14); Adult Office Visits ($23.86); and All Other Services ($20.00). On July 1, 1993, the conversion factor for Maternity Services was changed to $43.97 due to increased program funding and changes in RVUs; the Pediatric Services conversion factor was changed to $37.60 due to RVU changes (and a minor programming glitch); the Adult Office Visits conversion factor was updated to $24.69 due to changes in RVUs; and the All Other Services conversion factor was adjusted to $20.83 because of RVU changes.[7] The conversion factor update process, however, will depend primarily on the Legislature. For instance, the conversion factor for Pediatric Services will be updated on January 1, 1994 while the Maternity Services conversion factor is scheduled for an update on July 1, 1994.

The three payors rejected the use of Medicare Geographic Practice Cost Indices (GPCIs) to adjust fees for input price differences. Reasons for not using GPCIs included low statewide input cost variation and concern over access to care in rural areas. Instead of using GPCIs, RVUs were adjusted using a statewide geographical adjustment.

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[6]Differences in conversion factors across agencies are supposed to be short run, though the exact length of transition to a common conversion factor(s) across payors was not specified.

[7]The 1991 claims data used to produce the initial conversion factors were inflated up to 1993 before being used to calculate the updated conversion factors.

Payment Policy Components

Historically, Washington Medicaid has tried to maintain provider payment policies consistent with Medicare's. Medicaid changed their global surgery and bundled supplies policies to mirror Medicare's. The general definition of provider types and services covered by Medicare were adopted without any change. Specifically, providers to be reimbursed under the fee schedule included only those that were (1) also reimbursed under the Medicare fee schedule (MFS), (2) used CPT codes to bill for services, and (3) billed independently. Services were included under the fee schedule if (1) they were included in the MFS, (2) a CPT code or a local code that can be cross-walked to a CPT code exists, and (3) RVUs exist or can be imputed. Other Medicare policies were modified before being adopted and include:

- Payment for drugs incident to physician services,
- Payment for EKG interpretations,
- Payment for supplies and services incident to office services,
- Payment for assistant at surgery,
- Laboratory service payment,
- Differential payment for LLPs and NPPs,
- RBRVS transition period.

Medicaid's incidental drug payment rules do differ from Medicare's. For example, Medicaid has broader coverage for injection services than does Medicare. The Medicaid policy for payment for supplies and services incident to office services differs in several ways from Medicare's policy. First, Medicaid has fewer "bundled" supplies. Second, separate EKG payments are permitted. Third, CPT code 99070 (miscellaneous supplies) was eliminated, but providers now report supplies using HCPCS Level II codes. Finally, Medicaid reimburses providers for phone consultation services, after-hours services, and team conferences using imputed RVUs. Medicaid reimburses assistant surgeons 20 percent of the primary surgeon's fee rather than 16 percent used by Medicare.

Laboratory services not requiring physician involvement are outside the MFS and are paid by Medicare according to a separate non-RBRVS Medicare lab fee schedule. In contrast, the three Washington agencies incorporated lab services into their RBRVS fee schedules after imputing "artificial" RVUs from Medicare's conversion factor and the Medicare national lab fee schedule. Medicaid lab fees are prohibited from exceeding the Washington State Medicare lab fee schedule.

Limited licensed practitioners (LLPs) and non-physician providers (NPPs) are reimbursed equal to physicians for the same services. Nurse practitioners (NPs) and clinical nurse specialists (CNSs) will receive the full fee schedule amount under the Medicaid program whereas under Medicare, NPs and CNSs receive only 85 percent of the fee schedule amount (if the service is performed in a nonhospital setting; only 75 percent is paid if in a hospital).

Medicare is using a four year transition period in moving to a full RBRVS fee schedule. The Washington State RBRVS will limit fee changes to plus or minus 15 percent of prior fees. After one year, the program will be evaluated and a definitive transition schedule will be determined.

Medicare policies that were rejected outright include:

- New provider policy
- Site of service adjustment
- Procedure unbundling rules

Medicare's new provider policy pays "new" physicians, physical therapists, occupational therapists, and other health care practitioners 80 percent of the MFS amount, rising by five percent increments over four years to 100 percent. Medicaid rejected this policy because of concerns about access to care.

The site of service adjustment used by HCFA reduces the practice expense component for services performed in outpatient departments normally performed in physician offices. The rationale for the reduction is that the practice expense should be lower when performed away from the office and overhead expenses are covered by the payment to the outpatient facility. Washington State decided against this adjustment in favor of retrospective audits to detect instances of inappropriate use of setting.

HCA installed the Medicare standard unbundling software for claims processing, but neither workers' compensation or Medicaid have done so--they continue to use program-specific software and unbundling edits. For this reason, software standardization was temporarily rejected.

Finally, anesthesia and chiropractic services were excluded from the RBRVS fee schedule. Anesthesia is viewed as separate from the MFS because it has its own conversion factor and standard unit measure (i.e., time). Each program pays for anesthesia services differently, thus it was decided to defer the inclusion of anesthesia into the RBRVS fee schedule. Chiropractic services were also temporarily excluded from the RBRVS fee schedule

because the three public payors thought chiropractic services were inadequately covered with a single code in the MFS.

4.1.1.3 Discussion

The Medicaid program in Washington adopted the RBRVS methodology for reimbursement of physician services on January 1, 1993. Medicaid joined forces with HCA and workers' compensation to develop a common set of payment policy parameters and billing guidelines, then each agency developed its own conversion factor based on its own claims experience. Medicaid now uses four separate, budget neutral conversion factors according to type of service. The development of the Washington RBRVS represents the most thorough and comprehensive effort in the United States to date. It will serve as a model for other state level public payors to emulate in the future.

4.1.2 Michigan

4.1.2.1 Background

Michigan State Medicaid has fifteen to sixteen thousand participating physicians and has a monthly average of about one million enrollees. Currently forty percent of their enrollees are in a managed care arrangement. Of these, sixty percent (approximately 300,000) are in a capitated plan and the remainder are in a fee for service (FFS) plan. Michigan State Medicaid has two capitated plans and one fee for service physician case management plan.

Prior to the implementation of RBRVS, Michigan State Medicaid's payment system was a conglomerate of separate fee schedules that had been evolving since 1972. It was a combination of the 1972 California Relative Value Scale (CRVS), Medicare allowable rates, and manual review of special procedures.

By the late 1970's, Michigan State Medicaid fees fell below the usual and customary fees. In 1978-1979, there was a ten percent reduction in all fees due to a State fiscal crisis. After that, rates did not keep up with inflation. By 1985, Michigan State Medicaid had lost most integrity on the interpretation of procedure codes due to the high variation in the discretion over assigning procedure codes to physician services. As a result, fees for primary services were increased and the HCPCS coding system was adopted in 1985.

4.1.2.2 RBRVS Implementation

Development

Factors that motivated Michigan State Medicaid to move toward an RBRVS-based payment system include their desire:

- to increase access to care and reimbursement for primary care services, and
- to create equity among fees for physicians using fee screens.

In 1988, Dr. William Hsiao's work on the RBRVS concept was published. At this time, Michigan State Medicaid was increasing their reimbursement for primary care to establish equity among payments for services. In 1989, they contracted with Dr. Hsiao to simulate the consequences of RBRVS on Michigan Medicaid fees and to do a post evaluation of its impact on access. Dr. Hsiao used one year of Michigan's Medicaid claims data (about thirteen million claims) to perform simulations under three different scenarios:

- Budget neutral;
- Allowing for a ten percent increase; and
- A "hold harmless" budget neutral scenario (that allowed only for fee increases while fees were kept constant for those with simulated decreases).

Dr. Hsiao's results for Michigan were consistent with Medicare results: aggregate increases for evaluation and management (E & M) services and aggregate decreases for diagnostic and surgical procedures. In December 1989, these simulation results were presented to Michigan State Medicaid staff, a group of physicians, academia and various state legislative and administrative staff.[8] At this time, Michigan State Medicaid made the commitment to go ahead with the adoption of RBRVS. However, Medicaid had no funds to meet its goals of increasing primary care service fees and access to care while creating a rational payment system, so RBRVS was not adopted in 1990. In 1991, through a voluntary contribution plan negotiated between the Michigan Hospital Association and the State of Michigan using Federal Financial Participation (FFP)[9], sixty million dollars was made available for outpatient hospital and physician services. Using the voluntary contributions from the hospitals, Michigan increased its revenue from the Federal Government. The first transfer of funds was from October 1 to December 31, 1991, thus RBRVS had to be in place by the end of that fiscal quarter.

Program Design

RVUs and CFs

In anticipation of a December 1, 1991, implementation, 1990 paid claims data were used to match Medicare Relative Value Units (RVUs) with CPT codes. Simulations were performed using the Health Care Financing Administration's (HCFA) RVUs published in June 1991. RVUs were imputed for those procedures without RVUs with the help of a physician advisory panel of state medical societies.

Michigan State Medicaid estimated their own CF based on utilization of services and available funding. The impact on different types of services was shown, and minor adjustments were made. Obstetric, prenatal care and delivery fees were increased because

[8] Background information was provided by the Michigan Medicaid department.

[9] FFP is a process in which the Federal Government matches Medicaid expenditures according to a predetermined matching rate.

HCFA RVUs would have reduced them; and fees for mid-level and intermediate office visits for established patients were increased as well.

A CF of $19.40 was determined. Michigan State Medicaid incorporated their "hold harmless" simulation scenario that provided that if a fee would be decreased using the $19.40 CF, a CF of up to $24.80 could be used. This sliding CF scale was based on the promise Michigan State Medicaid made to the medical societies that they would not decrease any fee to less than eighty percent of Medicare's rate ($24.80 is eighty percent of the Medicare CF of $31.00). There were 6,524 fee screens changed; 5,045 were increased and 1,479 stayed the same or decreased.

There was largely no reaction to the change from the state's medical providers except a few individual complaints about specialty procedure codes. As of now, they do not have the capability for or the money to fund the updating of the RVUs. They are still using 1991 RVUs. The only 1992 RVUs used are those which were published for new procedures.[10] Michigan State Medicaid did not implement the rates until January 1992, but they were retroactive to December 1, 1991. All physicians, including those billing fee for service, were affected by the implementation of RBRVS. HMO rates were indirectly impacted since their rates are set at ninety percent of the comparable FFS rate.

Payment Policy Components

At the time of implementation, Michigan state Medicaid did not adopt any of the payment policies Medicare was implementing January 1, 1992. Medicare payment policies adopted or modified before being adopted include:

- *Payment for EKG Services.* Michigan State Medicaid does not pay for EKG services. Michigan plans to change this policy in accordance with Medicare.

- *Payment for Assistant at Surgery.* Currently they pay 20 percent of the primary surgeon's fee for assistant surgeons, but they will soon reimburse at 16 percent.

- *Global Surgery Policy.* This policy was adopted with some minor changes (i.e., an E & M visit can be billed separately but the surgeon's fee must be reduced accordingly). A one day pre-op and 30 days post-op is used.

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[10] As rates were being established for the implementation date of December 1, 1991, Medicaid received notice that Medicare's RVU changes would be published at the end of November. Medicaid then repeated nearly all their imputations and fee adjustments using the new RVUs.

- *Site of Service Differentials.* These have been in place since 1984. They apply a 60/40 split for professional components and overhead to a list of procedures, similar to Medicare's. For procedures on this list, they reduce the physician's fee sixty percent if the service is provided in a hospital setting instead of in the physician's office.

- *Anesthesia Payment.* Dr. Hsiao's initial simulations showed that anesthesia was overpaid compared to other specialties. Fee changes to any physician service were based on these initial simulations. It was decided that no changes were to be made to anesthesia upon the implementation of RBRVS and they removed anesthesia payments from RBRVS. Michigan State Medicaid wants their changes to correspond with Medicare's policies. At this time, anesthesiologists are paid using base units for surgical procedures.

- *Payment for Lab Services.* Clinical lab fees are not included in RBRVS and were not changed through the December 1991 process. However, pathology codes were changed. Payments for lab fees are based on a percentage of Medicare's rates. Medicaid's clinical lab fee payments are limited by statute. They cannot reimburse above Medicare's rates.

- *Balance Billing.* Physicians are not allowed to balance bill.

Policies Michigan State Medicaid did not adopt are:

- *New Physician/Practitioner Policy.* There will be no reduction in payment for new physicians.

- *Payment by Specialty.*

- *Geographic Adjustments.* Michigan State Medicaid does not adjust geographically. Instead, they use a GPCI published for the entire state of Michigan.

- *Behavioral Offsets.*

- *Volume performance standards.*

- *Transition payment rules.*

- *Differential payment for Limited License Practitioners (LLPs), Nurse Practitioners (NPs) and Physician Assistants (PAs).* Michigan State Medicaid has received a lot of pressure from the medical societies not to continue doing this because of responsibility differences. Mid-level providers are being paid "directly" under their employing organization (based on the physician identification number). These providers cannot bill independently and must have a written collaborative agreement with a physician. The payment then goes directly to the physicians or

organization in the name of the mid-level professional. If they become "independent," then the payment rate would probably be adjusted.

4.1.1.3 Conclusion

Michigan State Medicaid still has not made a fully "operational" transition to RBRVS. They are concerned about their data management and computer systems and their ability to maintain the RBRVS fee schedule and they do not have the technical ability to monitor their own system. Therefore, they have not been able to assess the impact of RBRVS on their system. Since 1991, a large number of people enrolled in Medicaid have moved from a fee for service plan to a capitated (managed care) plan. As a result, no evaluation has been done regarding the impact of RBRVS on the fee for service Medicaid population. The state is hoping to remedy this problem through the purchase of the software developed by the Cambridge Health Economics Group (CHEG).

4.1.3 Virginia

4.1.3.1 Background

The Medicaid program in the state of Virginia is currently considering adopting a resource-based relative value scale (RBRVS) approach for their physician payment system. The Virginia state Medicaid program ranks fourteenth out the 51 state Medicaid programs in spending on physicians services. In 1992, the state spent approximately $172,365,466 for physicians services.[11]

Although initial research regarding adoption of a RBRVS-based payment system began in mid 1991, formal discussions did not start until Spring 1993. A recommendation package was delivered to the state's Medicaid director in September 1993. The recommendation will outline the reasoning behind the proposed adoption; specific policy components to be adopted; and a suggested time frame for implementation.

4.1.3.2 RBRVS Implementation

Development

Prior to the developmental process, the state contacted other state Medicaid programs including Maine, Texas, Michigan, Washington, Georgia, and Florida for insight and assistance. These states were selected as a result of their interest in and/or adoption of an RBRVS-based payment system.

Beginning in March of 1993, a physician advisory committee was convened by the state Medicaid director. It was comprised of representatives from state-level medical and specialty societies and met periodically with the intention of developing a recommendation regarding the adoption of RBRVS. The committee submitted a report to the Virginia Department of Medical Assistance Services director in October 1993. The committee recommended implementation of RBRVS methodology without modifications.

In an effort to improve Medicaid recipient's access to care, there has been a specific attempt in the state to maintain generally high levels of payment for Medicaid services, especially obstetrical services. Over the recent years, the state has increased fees for primary care physicians and they believe current levels of access are good.

The state's main reason for adopting a RBRVS-based payment system is to secure Medicaid's recipients access to care, especially office visits. Unfortunately, adoption of a

[11] SOURCE: HER calculation using the HCFA 2082 data base, 1992.

resource based system would actually *lower* physician reimbursement for obstetrical services; a change which is contrary to recent efforts in the state. Lowering fees for obstetrical services was not an intended result of the proposed system, but could occur because fees are already high relative to RBRVS obstetrical fees. The issue is currently under discussion and has drawn substantial interest.

The state also views adoption of RBRVS as a way of staying competitive. There was concern that physicians in the state would be less likely to accept Medicaid patients if their rates were not competitive with other payers in the state, including Virginia Blue Cross and Blue Shield, which is in their second of five years of a phase-in to an RBRVS-based payment system.

It is expected that implementation will begin in July, 1994 and will be phased in over a three year period. There are, of course, numerous opportunities for modifications or additions to be made to the current form of the proposal prior to its implementation. For example, it is uncertain as of yet whether the new payment system, if adopted, would be implemented by regulatory procedures or by state statute.[12]

Program Design

Virginia's budget-neutral RBRVS payment system will be based on Medicare's Relative Value Units (RVUs) and will be applied to all Medicaid physicians. The state is using the 1993 RVUs in combination with state-level claims data to develop their own conversion factors. The issue of updates to the fee-schedule remains outstanding. There has been extensive debate regarding whether the fees will be updated following an annual review process or whether they will be automatically updated by a predetermined inflation factor. No decision had been made at the time of the interview.

Relative Value Units and Conversion Factors

Using the 1993 RVUs and state-level claims data from one quarter of 1992, Virginia developed state specific conversion factors (CFs). Two CFs, one for surgical services and one for evaluation and management services, will be proposed. The claims file was sorted by expenditure and by procedure code to obtain the top (most commonly occurring) 500 codes. This step captured about 90-95% of total physician expenditures. About 100 codes (lacking

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[12]Although modifications may occur, it appears that the new system *is* likely to be accepted. This review is based on the state's proposal as of August, 1993.

RVUs) were trimmed out, leaving about 400 codes (constituting about 75% of expenditures) in the final file.

For the approximately 25 percent of procedures that did not have assigned RVUs, payment of services will continue based on the current fees. Examples of non-RVU codes include immunizations and preventive services. Preventive fees will be set to track the increase in fees which is occurring for evaluation and management procedures. However, the state anticipates that as new RVUs are established and adopted by Medicare, it is likely that the state will adopt them as well.

The proposed CFs will be 96 percent of Medicare's CF. The implications of the new system will be similar to those of Medicare, where payment for primary care services will be increased and payment for specialty services will be decreased.

Payment Policy Components

Many of the policy components that accompanied Medicare's implementation of RBRVS will most likely not be adopted. The state's focus is on the technical components of the payment system, not the associated policy components. The state inferred that adoption of an RBRVS-based payment system would be more feasible and politically acceptable if this approach were taken.

- *Global Surgery Policy.* The state chose not to adopt Medicare's surgical services definitions, citing that their payment rules are already similar to Medicare's. The state will maintain its current cost monitoring system which retrospectively profiles physician claims and examines them for unbundling.

- *Anesthesia Payment.* An anesthesia payment system will not be adopted; anesthesia services will continue to be paid based on current fees.

- *Nonphysician Providers.* Payment is made on the same schedule as physicians. Non-physician providers must be enrolled in the Medicaid program in order to receive payment.

- *Balance Billing.* Balance billing of patients will not be permitted, yet copayments will still be allowed.

Finally, the state will not adopt the nonpayment of EKG interpretations policy, site of service payment differentials, or volume performance standards. Payments will not be geographically adjusted; all physicians in the state will be paid equally for the same procedure

regardless of location. Medicare's geographic practice cost indices were rejected because they would have reduced payments to physicians who practice in locations which are currently under-served.

4.1.3.3 Discussion

Although a number of issues must be resolved prior to the actual implementation of this system, substantial progress has been made in the area. If plans continue as expected, the state's Medicaid Board will receive the proposed changes shortly after its review by the state's Medicaid director and will be implemented in mid-1994.

4.2 Workers' Compensation

4.2.1 Workers' Compensation Fund Of West Virginia

4.2.1.1 Background

The Workers' Compensation Fund of West Virginia (WCF) is a self-supporting division within the Bureau of Employment Programs. WCF receives mandatory premiums from most employers in the state, but does not receive general revenue funds from the state. The goal of WCF is to provide workers with prompt relief from the effects from the physical and economic effects of work-related injuries while, at the same time, protecting employers from the effects of costly litigation. By law, the commissioner of WCF is charged to "fix and maintain the lowest possible rates and premiums consistent with the maintenance of a solvent workers' compensation fund."

Since the WCF is self-supporting, control of medical care costs and disability benefits are essential to constraining increases in premium rates. To this end, two major initiatives have begun. The first is a utilization management program focusing primarily on musculoskeletal injury claims that aims to reduce unnecessary utilization while, at the same time, facilitating timely return to work. The second is to develop a physician reimbursement methodology to replace the present fee schedule, which is an 80th percentile fee schedule based on the usual, customary and reasonable (UCR) charge methodology. Fees are considered as maximums and payment in full since there are no beneficiary deductibles and copayments and balance billing is not permitted.

4.2.1.2 RBRVS Implementation

Development

The present physician fee schedule, which has been operational since April 1, 1988, was viewed as a temporary response to the upward spiraling costs of physician services. The Omnibus Health Care Act (S.B. 576) enacted by the West Virginia State Legislature in 1988, however, called for all state departments and divisions that pay for health services (Public Employees Insurance Agency (PEIA), Medicaid, the Division of Rehabilitation Services, and Workers' Compensation Fund) to work together to establish a physician payment methodology that will ensure "fair, equitable, and cost-effective" compensation for services.

To facilitate development of such a methodology, the WCF entered into a contract with Health Economics Research, Inc., in March 1991 for a study that would:

- Evaluate current patterns of payment to physicians;
- Project the effects of alternative physician payment strategies on the costs and distribution of payments among physicians; and
- Recommend a payment methodology based on discussions with the Health Care Advisory Panel[13] and the study's findings.

WCF directed HER to develop models based on the RBRVS methodology. WCF's major objectives for pursuing an RBRVS-based fee schedule were to:

- Create/establish a fair, equitable payment system while also containing growth in costs; and
- Reward primary care physicians.

The HER study, submitted in September 1992, showed physician payment redistributions by specialty, location, and specialty/location combinations arising from three separate RBRVS-based fee schedules. The HER study used 1989 and 1990 WCF physician claims data. A recommendation was made by HER to WCF to continue its development of an implementable RBRVS fee schedule which uses newer, cleaner claims data and fully addresses physician billing guidelines.

After the Health Care Advisory Panel reviewed the HER study, WCF program administrators met with officials at PEIA and Medicaid in the Spring and Summer of 1993 and agreed to pursue the implementation of an RBRVS fee schedule.

Program Design

WCF is now in the preliminary stages of developing a new RBRVS fee schedule to be (tentatively) implemented on July 1, 1994. On August 17, 1993, HER submitted a proposal to PEIA--which is acting as the administrative liaison between HER, WCF and Medicaid--to develop RBRVS fee schedules for the state's three major public health care payors. Information below about the development of the WCF's RBRVS fee schedule is based on conversations with WCF program officials and the proposal submitted by HER.

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[13]The Health Care Advisory Panel is a physician advisory panel assembled by WCF to review program issues.

The three major public payors of health care in West Virginia have agreed in principle to pursue RBRVS for their physician payment system.[14] However, a movement toward a common fee schedule for all three payors has not been decided upon since such a move would result in large payment redistributions by payors. They intend to follow the Washington State model by developing a representative provider advisory panel. The panel will include physicians from various specialties and other nonphysician providers. The purpose of this panel is to develop a consistent set of policy rules (wherever possible) across the three payors and to explicitly incorporate physicians and other health care providers into the decision process. HER staff and a physician consultant will assist the advisory panel in developing payment policy rules. The policy development phase will conclude with a final set of payment policy rules to be adopted by all payors plus a subset of payor-specific payment rules.

Prior to promulgation of final payment polices, each payor will be sending physician claims data to HER for developing a conversion factor and fee schedule. Development of the fee schedules will proceed after final payment policy rules are given to HER so as to incorporate specific payment policy algorithms into the models.

RVUs and Conversion Factors

The proposed project to create RBRVS fee schedules will utilize Medicare's 1993 RVUs, but will not use Medicare's GPCIs. Each payor will have its own conversion factor(s) based on its own claims history.

Payment Policy Components

WCF's movement toward RBRVS necessitates a policy development phase that will create a consistent set of payment policy parameters across the three agencies. However, it is likely that each individual agency will retain some program-specific policies, perhaps due to their unique patient mix. Although it is premature to speculate on which current WCF payment policies will be retained or modified, a description of current policies now in use is provided below.

- *Global Surgery Policy.* WCF generally uses a 90-day period which applies to most surgeries and is very similar to Medicare's. Some procedures, however, have specific pre- and post-op windows.

[14] A contract agreement has not been consummated as this time.

- *Anesthesia Payment.* WCF's automated processing system uses base units. The system adds time and base units, then multiplies the sum by a conversion factor to get the fee. This works out to about $31.50/unit.

- *Assistant at Surgery.* WCF has an established schedule where unit values are applied to surgical procedures. Surgical fees are then calculated by multiplying unit values by a conversion factor (about $75/unit). The decision rule is: If unit values are greater or equal to ten, then an assistant at surgery gets a fee, otherwise no fee is paid to the assistant.

- *Multiple Surgery Policy.* WCF's policy is identical to Medicare's whereby additional surgeries receive reduced fees.

- *Payment for Supplies and Services Incident to a Physician's Services.* The WCF policy departs from Medicare's, but some minimal office supplies are reimbursed up to $25 using code 99070. Supply expense over $25 requires the provider to bill by specific HCPCS code.

A large share of physician claims for WCF come from chiropractitioners, orthopedic surgeons, and neurosurgeons. WCF reimburses chiropractitioners for office visits, physical medicine, and radiological procedures. Orthopedic surgeons and neurosurgeons, on the other hand, are accorded no specific or special payment rules. Finally, WCF will not adjust physician fees by geographic location because of a general perception that input prices do not vary significantly across the state and WCF does not want to pay lower fees to rural physicians vis-a-vis urban physicians.

4.2.1.3 Discussion

The workers' compensation fund in West Virginia is pursuing an RBRVS fee schedule that will be implemented on July 1, 1994. Coordination between WCF, PEIA and Medicaid will be necessary to develop a common, consistent set of payment policy parameters. Each agency will have its own conversion factor(s) and fee schedule, however, based on the payor's own physician claims experience. Movement to a common conversion factor(s) is uncertain, but West Virginia has already made a bold step in the direction of an all-payer system for physician services based on the RBRVS methodology.

4.2.2 Office Of Workers' Compensation Programs

4.2.2.1 Background

The Office of Workers' Compensation Programs (OWCP) within the U.S. Department of Labor is the agency that administers the Federal Employees' Compensation (FEC) program. The explicit goal of FEC is to protect Federal workers from the economic effects of work-related injury or disease. Under the Federal Employees' Compensation Act (FECA), more than three million Federal workers are entitled to first-dollar coverage for medical expenses related to injury or disease sustained at work. The FECA originates from the United States Employees' Compensation Act (USECA), which took effect on September 7, 1916, and was the nation's first workers' compensation law for Federal employees. USECA created the Employees' Compensation Commission to process workers' claims and pay benefits from a special fund--the Employees' Compensation Fund.

Benefits under FECA include coverage of all medical expenses for work related injury or illness, payment for lost wages from disability due to traumatic injury[15], and "schedule awards" to workers or their dependents from permanent disability or death. All benefits under FECA are paid from the Employees' Compensation Fund which is funded by "chargebacks" to participating Federal agencies.[16] That is, the Fund pays out benefits--e.g., payments to physicians--then bills the agencies for those costs.[17]

In fiscal year 1992, FEC paid benefits for work-related injuries or illnesses on behalf of over 250,000 Federal workers in excess of $1.75 billion. The majority of payments were for lost wages due to permanent ($997 million) or temporary disability ($200 million), another $444 million went to medical care and rehabilitation providers while the residual was for death benefits to surviving dependents of deceased workers ($110 million).

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[15]Employers pay the first 45 days of lost wages for traumatic injury. Beyond 45 days, the FEC program pays the worker at two-thirds of full wages if the worker has no dependents, 3/4 if the worker has at least one dependent.

[16]The largest agencies include the U.S. Postal Service, Navy, Army, Air Force, Veterans Administration, Department of Transportation, Tennessee Valley Authority, and U.S. Treasury.

[17]Since most agencies include their workers' compensation expenses in their annual appropriation request, chargebacks are received by FEC about 15 months after incurred expenses. The "float" expense shortfall is absorbed by the Department of Labor (DOL). In addition, DOL covers another $53 million not covered by chargebacks.

4.2.2.2 RBRVS Implementation

The FEC program has not been immune to the general increase in medical care expenditure experienced by other payers of health care: It has had rapidly escalating medical expenses, rising from $69 million in FY 1977 to $165 million in FY 1984. Between 1980 and 1987, medical care expenses increased by more than 90 percent, or nearly twice the rate of medical care inflation (in the CPI). Recent changes in the FEC program reflect, in part, a response to rising expenditures and a desire to improve the review process for health care claims. OWCP's conversion to the HHS HCFA RBRVS is being done to improve the appropriateness of their reimbursement distribution and for consistency among Federal programs.

Development

OWCP has been using an RVS-based fee schedule similar to Medicare's since 1986 when it adopted the Washington State schedule which uses relative values for physician services, identified by the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes and a conversion factor.[18] While rising medical care expenditures were an important concern for the FEC program, cost containment was not the primary factor for adopting the Washington State RVS. As early as 1982, OWCP began to search for an alternative payment system to its UCR system because of inconsistent criteria for screening and reviewing service claims used by OWCP District Offices.[19] The primary objective for adopting the Washington State RVS, therefore, was to create consistent criteria for reviewing provider charges and service volume and intensity; and subsequently to control inappropriate care.

The OWCP applied the Washington State RVS nationally with four conversion factors--one each for surgical services, medical services, radiology services, and lab services. OWCP made adjustments to allowed maximum charges across geographic areas through the use of geographic cost indices. The cost indices were developed from an analysis of Medicare Part B[20] county specific data. Medicare program data was then adjusted, based on the analyses of

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[18] The Washington State RVS was created by the Washington State Department of Labor and Industries through its adoption and modification of the California RVS (which is charge-based). The Washington State Department of Labor and Industries annually revised its relative value units until it adopted Medicare's RVUs in 1993.

[19] OWCP reviewed the Health Insurance Association of America (HIAA) medical fee schedule but decided against its adoption because it was not comprehensive; it only covered surgical fees. The major FEC costs are for medical services, physical therapy, radiology, and pathology.

[20] OWCP's geographic index utilized Medicare Part B enrollee cost information at the county level which was aggregated up to the Metropolitan Statistical Area (MSA) level.

FEC data for major MSAs. (Medicare expenditure data was found to be highly correlated with FEC expenditure data.) The OWCP conversion factors were updated according to the Medicare Economic Index (MEI). Also, adjustments to OWCP's fee schedule were made annually based on changes to relative unit values made by the Washington State Department of Labor and Industries.

On May 14, 1991, OWCP expanded coverage under its fee schedule to include outpatient hospital-based services (radiology, physical therapy, and pathology). Prior to this change, these services were excluded from the fee schedule, resulting in differential payments for the same service depending on the type of outpatient setting.

The key reasons leading to OWCP's decision to adopt the Medicare RBRVS were: 1) consistency among Federal programs, 2) the quality of the Medicare product (which was developed by a group of experts with a broad knowledge of medicine), and 3) the national scope of the program. The fact that Medicare will be maintaining the Medicare Fee Schedule (RVUs and geographic practice cost indices) is an important consideration for OWCP.

Program Design

The OWCP has studied the impact of converting to a fee schedule based on Medicare's RVUs and expects to adopt Medicare RVUs as the basis of its fee schedule. Their original strategy was to move to an RBRVS fee schedule after the Medicare Fee Schedule transition period in 1996. However, the decision by Washington State to adopt Medicare's RVUs in 1993 accelerated OWCP's plans for adopting Medicare RVUs.

RVUs and Conversion Factors

The OWCP anticipates adoption of Medicare's RVUs for its fee schedule on January 1, 1994. Overall, OWCP accepts the relativity concept of Medicare RVUs as reasonable and appropriate. They do not expect to adopt the same conversion factors used by Medicare because they are currently calculating their own based on Medicare's conversion factors, their own claims and utilization experience, and their program goals.

Payment Policy Components

The population covered by FECA is generally younger and healthier than the Medicare population and consumes a different mix of medical services.[21] OWCP does share a number of billing practice guidelines and payment policies with Medicare. Presently, OWCP has the following payment policy profile:

- *Geographic Fee Adjustments.* OWCP uses its own geographic cost indices based on Medicare expenditure data and some of their own data. Under RBRVS, OWCP will adjust its fees nationally using the Urban Institute/Center for Health Economics Research (UI/CHER) Geographic Practice Cost Index (GPCI) values as developed for Medicare, but based on MSA geographic localities.

- *Assistant at Surgery.* The assistant surgeon receives 20 percent of the primary surgeon's fee in most instances.

- *Site of Service Adjustments.* No such adjustments are made. Also, services at Ambulatory Surgical Centers (ASCs) are not paid differently from other settings.

- *Global Surgery Package.* OWCP does not use a global service definition other than that indicated by CPT to pay for pre-and post-surgical services along with the surgeon's services. However, they do hope to adopt Medicare's global surgery policy after implementation of RBRVS.

- *Physician and Nonphysician Providers.* OWCP defines physician service providers to include physicians, clinical psychologists, doctors of osteopathy, chiropractors, certified registered nurse anesthetists (CRNAs), physical therapists, and occupational therapists. No fee discrimination is made among these providers. OWCP is now reviewing its payment policy for nurse practitioners and physician assistants, currently not usually subject to the OWCP fee schedule.

- *Radiology Services.* A 40-60 split is used for procedures other than imaging and computerized axial tomography, as done in the Washington RVS, to allocate payments for overhead (60%) and professional (40%) components.

4.2.2.3 Discussion

In 1986, the OWCP, faced with inconsistent medical care claim review processes across the nation and swift increases in medical care expenses, implemented a fee schedule based on

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[21] Approximately 50 percent of the FEC program's medial expenses are for office visits and physical therapy.

the Washington RVS. Health care costs continued to increase after implementation of the fee schedule, partly due to the limited influence a fee schedule has on the nature and frequency of health care services provided.[22] Other reasons why costs are continuing to rise is that the fee schedule allows those providers with low historical charges to raise their charges to the fee schedule level while other providers with historically high charges may seek to maintain their income level by increasing volume--either absolute volume or intensity of services per encounter.

Legislatively, OWCP remains committed to pay the full amount for all "reasonable" care to injured workers. After the implementation of the Medicare fee schedule, OWCP began to make plans to assimilate their schedule with the Medicare schedule. This will make it easier for OWCP to adjust reimbursements consistent with the Medicare goals for improved distribution of payments for services. The goal of measuring reasonableness of medical services and achieving cost containment will remain elusive, however, because of current variations in medical practice, indemnity issues associated with industrial inquiries and legalities associated with worker's compensation.

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[22] The OWCP fee schedule covers outpatient services or professional medical services, accounting for 80% of total FEC medical care expenses. Inpatient care is not subject to the fee schedule.

4.3 Military and Veteran's Health Care System

4.3.1 CHAMPUS

4.3.1.1 Background

The Department of Defense (DoD) currently spends about $17 billion annually on health care. Of this total, $8 billion goes to the DoD direct care system--a network of over 140 military and community hospitals and 500 outpatient clinics. Nearly eight and one-half million people are eligible to receive health care in the DoD direct care system, but only active duty service members (1.8 million) are entitled to this care. Other beneficiaries include dependents of active duty personnel (2.6 million); and military retirees and their dependents, and survivors of active or retired military personnel (4 million). All non-active beneficiaries are not entitled to health care in the direct care system, but can receive access based on availability. About 75 percent of care for DoD beneficiaries is provided in the direct care system.

About $4 billion are spent to finance the civilian health care provided to program beneficiaries via the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS is a supplemental program to the direct care system within DoD created to pay for health care provided in the civilian sector to military beneficiaries. It is administered by the Office of CHAMPUS (OCHAMPUS) which also sets program policy. All DoD beneficiaries are CHAMPUS eligible except for those over age 65 (about 1 million) who become Medicare eligible. The CHAMPUS program covers inpatient and outpatient care, pediatric services, psychiatric services, and substance abuse treatment outside of military health care facilities (hospitals, clinics).

A catchment area of 40 miles around a military hospital defines whether a beneficiary can use a civilian facility without prior approval. Within the 40 mile catchment area, a "nonavailability statement" must be obtained from the local military medical commander stating that hospital care was not available in the local military hospital. Outpatient care, including physician office services, can be used at the discretion of the beneficiary: there is no requirement for the nonavailability statement, except for some specified outpatient surgical procedures. CHAMPUS serves as a secondary payor to private health insurance policies.

4.3.1.2 RBRVS Implementation

Development

Historically, CHAMPUS has adopted many Medicare features because of similarities in administration and general structure. The use of RBRVS by CHAMPUS therefore seems to be a predicted step in its evolution. The specific use of RBRVS does differ significantly from that of Medicare, however. To better understand these differences, a brief summary of physician payment and recent developments by CHAMPUS is required.

CHAMPUS pays physician services based on allowable charges, where actual payment is the lesser of a prevailing charge in the area or the submitted charge for the service. Historically, prevailing charges were based on an 80th percentile scale on a state-by-state basis. In recent years, several changes in reimbursement policy have been implemented in response to cost growth.

First, in 1989, Congress mandated that growth in CHAMPUS prevailing allowable charges be limited by the Medicare Economic Index (MEI). The DoD Appropriations Acts of 1991 and 1992 required CHAMPUS to identify overpriced procedures by comparing its prevailing allowed charges with Medicare's preliminary relative value units (RVUs).[23] A reduction of up to 15 percent was applied to those overpriced procedures--those identified as being at least fifty percent above Medicare's. An analysis indicated that CHAMPUS prevailing charges were 1.53 times Medicare RVUs, on average.[24] Procedures found to be overpriced by Medicare under OBRA 1989 had an RVU ratio of 2.31 for CHAMPUS. Overpriced procedures determined under OBRA 1990 were found to have an RVU ratio of 1.93 for CHAMPUS. Primary care services had an overall RVU ratio of 1.37 while pathology services showed a ratio of 2.76 for CHAMPUS to Medicare RVUs. Final fee adjustments under the 1992 DoD Appropriation Act were based on final Medicare RVUs and included increases in primary care services by the MEI, reductions in fees of 15 percent for procedures with RVUs 1.5+ times Medicare RVUs (i.e., overpriced procedures from OBRA 1989 and OBRA 1990 and pathology services), and a continuation of the 1990 fee for those services being neither overpriced or primary care. Also, on May 1, 1992, CHAMPUS began to establish national maximum

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[23] Preliminary Medicare RVUs were published in the *Federal Register*, September 4, 1990.

[24] Technically speaking, CHAMPUS prevailing charges were divided by the Medicare conversion factor to get imputed CHAMPUS RVUs. A ratio of imputed CHAMPUS RVUs to Medicare RVUs was then taken. These imputed values were weighted by the frequency of procedures for CHAMPUS to get an overall average ratio of CHAMPUS to Medicare RVUs.

allowable charges adjusted by Medicare's Geographic Practice Cost Indices (GPCIs) based on Medicare payment localities (rather than statewide adjustments used previously). In effect, this change allowed CHAMPUS to administer prevailing charge levels at the local level rather than at the state level.

Rapidly expanding program outlays for physician services were the chief motivation behind CHAMPUS's "adoption" of RBRVS. Underlying causes for the growth in physician expenditure include the very nature of the prevailing allowable charge system. The old payment system was inflationary, even with the imposition of the MEI update factor. In addition, the establishment of charges on a statewide basis led to payments that were improperly aligned with physician costs in urban and rural areas.

CHAMPUS has high expectations and a positive perception of RBRVS. It sees RBRVS as a tool for controlling costs, rationalizing physician payments, and avoiding or minimizing "cost shifting" by providers. In addition, CHAMPUS expects RBRVS to simplify the administration of its national program and to help it become more compatible with the Medicare program. CHAMPUS officials do not expect the RBRVS system to lead to any serious disruption in physician relations.

The major concern over RBRVS is its potential impact on beneficiary access to care. The program has implemented specific safeguards to ensure against access problems. First, reductions in any overpriced procedure can be waived by the Director of CHAMPUS if access to care is jeopardized. Second, for any procedure with a frequency of at least 50 in a locality and a fee reduction greater than 15 percent (from the use of GPCIs and overpriced procedure reductions), the combined reduction will be limited to a maximum of 15 percent. Third, if balance billing is observed on 40 percent or more of claims for a procedure in a locality, the overpriced procedure reduction will be waived.

Although CHAMPUS installed access safeguards, the keys to overcoming access concerns--and ultimately embracing RBRVS--were its experience with limits on prevailing charges and the early Medicare experience under the Medicare Fee Schedule (MFS). In particular, physician participation in the CHAMPUS program actually increased at a time when maximum allowable charges were being limited. Evidence from the Medicare program shows that more than 92 percent of physicians with significant Medicare patient loads are still accepting new Medicare patients post-MFS (ProPAC, 1993). CHAMPUS plans to continue monitoring the Medicare experience and its own beneficiaries' access as its physician payment reform efforts proceed.

Program Design

Current CHAMPUS use of RBRVS is defined by the 1993 DoD Appropriations Act. CHAMPUS now uses a new standard to determine overpriced procedures: CHAMPUS maximum allowed charges greater than the fully phased in Medicare Fee Schedule amount (instead of 1.5 times Medicare RVUs) will be considered overpriced. Overpriced CHAMPUS procedures will be reduced by no more than 15 percent per year. The explicit policy objective of this Act for CHAMPUS can be summarized by the excerpt below from the *Federal Register*[25]:

> "Section 9011 provides Congressional direction to reduce CHAMPUS payment limits for professional services towards the Medicare limits for similar services, and to proceed gradually by reducing each CHAMPUS payment limit by no more than 15 percent per year."

The CHAMPUS shift from statewide prevailings to use of the Medicare localities was "budget neutral." However, the 15 percent reduction for overpriced procedures was taken as program savings and was not reallocated. Furthermore, 1992 prevailing charges that were compared to fully phased in Medicare fees were determined using a complicated process. Specifically, CHAMPUS used 1987 prevailing charge data[26], updated using the MEI, and compared it to 1991 charge data on a procedure by procedure basis. The lower fee for each procedure was chosen, then compared to Medicare's value to determine if the procedure was "overpriced."

In terms of updates, CHAMPUS has been in a "freeze mode" the past three years except for overpriced procedures and primary care services. Primary care procedures have been increased by the MEI while overpriced procedures have been cut, even if the overpriced procedures were classified as primary care.[27] For most procedures, fees will decline over the next several years, until they reach the Medicare level. Future fees will then depend in large part on the changes in Medicare conversion factors, which are updated according to Congressional action or a default method based on the Medicare Volume Performance Standards (MVPS).

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[25]Source: *Federal Register*, Vol. 56, No. 238: 58428. Thursday, December 10, 1992.

[26]1987 charge data predates the use of MEI updates. These data were selected to limit the influence of the MEI updates to 1991 prevailing allowable charges only.

[27]Most overpriced primary care services were obstetrical (OB) services. The OB service fee reductions were essentially restored after Medicare raised the OB RVUs for 1993.

RVUs and Conversion Factors

CHAMPUS uses Medicare RVUs to establish physician service fees in an indirect manner by pegging maximum allowable fees to the Medicare fee schedule. During the transition period, CHAMPUS allowable charges will converge toward Medicare fees. After the transition is complete, CHAMPUS fees will essentially be based on Medicare RVUs and conversion factors. DoD has sought Congressional authority to adopt the Medicare fee schedule to CHAMPUS (using a CHAMPUS conversion factor), but has been unsuccessful to date.

Physician Payment Policies

Physician payment policy issues received very little attention from CHAMPUS during its analyses of RBRVS. The program had been using five different fiscal intermediaries (FIs), and much authority for payment policy was delegated to the FI. Thus, payment policy varied across the country before centralizing this function. CHAMPUS does incorporate geographic fee adjustments indirectly by establishing national maximum allowable charges adjusted by Medicare's GPCIs based on Medicare payment localities. Effective in 1994, balance billing limits will be identical to Medicare's limit: 115 percent of allowable charge. Also, a five percent differential will be imposed for nonparticipating providers--i.e., those providers that do not join the Participating Provider Program whose members accept CHAMPUS allowable charges as payment in full.

Other CHAMPUS physician payment policies do not coincide exactly with Medicare's, but there is considerable overlap and consistency with respect to specific policy issues.

- *Assistant at Surgery Policy.* CHAMPUS pays an assistant at surgery 20 percent of the primary surgeon's fee, and the charge must be billed through the (CHAMPUS authorized) employing physician. This policy has undergone only minor modifications over time.

- *Global Surgical Policy.* CHAMPUS pays for surgeons' services on a bundled basis using a pre- and post-operation window as does Medicare.

- *New Physician/Practitioner Policy.* CHAMPUS does not make different/lower payments to new providers as done by Medicare.

- *Payment for "local" codes priced by insurance carriers.* CHAMPUS does allow FIs to develop prices for some codes. There is no basis for determining whether these

procedures are overpriced, though the fees have been frozen. For anesthesia, there is no basis for comparison, but they are paid on a statewide prevailing charge basis.

- *Multiple Surgery Policy.* CHAMPUS pays for multiple surgeries at a diminishing rate as done by Medicare.

- *Nonpayment of EKG Interpretations.* CHAMPUS does provide payment to physicians for EKG interpretations.

- *Geographic Practice Cost Adjustments.* CHAMPUS now uses Medicare's GPCIs to adjust national maximum allowable charges.

- *Limited Licensed Practitioners.* Payment policies for nonphysician providers have both similarities and differences to Medicare's. Fees for nonphysician providers are constrained to be equal to or less than payments to physicians.

4.3.1.3 Discussion

The use of RBRVS by CHAMPUS can not be considered a "wholesale" adoption; but in practice physician fees will be close to those for Medicare. Under the 1993 DoD Appropriations Act, CHAMPUS is in a gradual transition toward Medicare fees. In addition, CHAMPUS shares a number of physician payment policies with Medicare.

Expectations are high and perceptions of RBRVS are positive. However, a major concern for CHAMPUS in moving to an RBRVS physician payment system is the potential impact on beneficiary access to care. Concerns about access to care have been assuaged by the implementation of access safeguards and previous experience on physician behavior under fee limitations.

4.4 Traditional Indemnity Insurers

4.4.1 Mutual of Omaha

4.4.1.1 Background

Mutual of Omaha has traditionally been an indemnity insurer. However, they offer several product lines including indemnity, Medicare supplements (Medi-Gap), and managed care products that include HMOs and PPOs. Policies are sold to individuals, small groups, and large groups. Mutual of Omaha also administers benefits for self-funded groups. Health care products are sold and managed directly by Mutual of Omaha, as well as through their subsidiaries. For example, Exclusive Healthcare, Inc. is the subsidiary for their HMO products. Mutual of Omaha has traditionally used the Usual, Customary, and Reasonable (UCR) reimbursement system for indemnity physician payment. Maximum allowable charges for the UCR system are typically about twice as high as Medicare's payments for most procedures, and three times as high for radiological procedures. Mutual of Omaha uses negotiated fee schedules and capitations for physician payment in their managed care networks.

4.4.1.2 RBRVS Implementation

Development

Mutual of Omaha has approximately fifty networks that are locally operated. Most of these networks are "rented" by Mutual of Omaha. Several have considered using RBRVS, but only two (at the time of this writing) have chosen to "adopt" the RBRVS system. Both networks that adopted RBRVS are PPOs located in the Northwest: Seattle, Washington and Portland, Oregon.

The two networks using RBRVS went with a one-time implementation process which began in the Spring of 1993. A phase-in process was viewed as an unnecessary inconvenience. According to a Mutual of Omaha representative, the two PPOs that adopted the RBRVS system were motivated by a dissatisfaction with the 1974 California RVUs they were using, which covered only 50% of their physician services. Secondly, they both may have been influenced by the general RBRVS movements in their respective states. A third PPO has notified Mutual of Omaha regarding their interest in using RBRVS.

Program Design

The Mutual of Omaha's PPOs are essentially using RBRVS as a fee screen to set maximum allowed charges. Providers are paid the lessor of the billed charges or the fee schedule amount based on the RBRVS.

RVUs and CFs

The Seattle network is using the 1993 RBRVS unit values without any Medicare GPCI adjustments. They are using two conversion factors - one for surgery and one for all other services. The Seattle network created relative values for lab procedures, preventive medicine procedures, and other CPT-4 procedures that did not have RBRVS relative values.

The Portland network is using the 1992 RBRVS with the Portland GPCI adjustments. They made modifications to several relative values including the obstetrical values. They are using McGraw-Hill's Relative Values for Physicians (RVP) relative values for laboratory and pathology procedures. The Portland network is using a single conversion factor for surgery, radiology, and medical services. Laboratory and pathology services have a different conversion factor since they are based on the McGraw-Hill RVP.

The conversion factors selected by the two networks are higher than those selected by Medicare. Payment levels are approximately 150% of the Medicare allowed charges. Fee schedules are reviewed annually and both organizations have a history of good physician participation, including the period following revision of their payment system.

Payment Policy Components

Mutual of Omaha has a number of payment policies that differ from those used by Medicare. The physician payment policy profile of Mutual of Omaha resembles the following:

- *Reduced Fees for New Providers.* Mutual of Omaha does not apply a fee differential for physicians or other providers with limited years of practice.

- *Assistant at Surgery.* Assistant surgeons are paid at 20 percent of the primary surgeon's fee rather that the 16 percent used by Medicare.

- *Site of Service Differentials.* Mutual of Omaha does not apply fee differentials based on site of facility where services are performed.

- *Bilateral Surgery.* Mutual of Omaha maintains a policy on bilateral surgeries similar to Medicare's. Bilateral procedures are paid 150 percent of the procedure done on a unilateral basis (in the absence of any evidence with respect to actual difference in

work). Modifier 50 is used to indicate those cases where a procedure which is normally done on one side of the body is done on both sides of the body.

- *Multiple Surgery.* Primary surgeries are paid 100 percent while additional procedures are paid at 50 percent of the highest valued procedure. Mutual of Omaha is moving towards Medicare's policy which pays 100 percent of the global fee for the highest valued procedure only, then 50 percent of the global fee for the second most expensive procedure, and 25 percent for all subsequent procedures (those procedures beyond the fifth require submission of special documentation).

- *Chiropractic Services.* Mutual of Omaha will pay chiropractors for x-rays and other services in addition to just subluxation treatment. (State laws prohibit Mutual of Omaha from differentiating fees on the basis of a provider's degree. Therefore, a D.O. and an M.D. will receive the same fee for an X-ray, for example.)

- *Balance Billing.* All providers in Mutual of Omaha's networks sign agreements that prohibit balance billing--negotiated fees represent payment in full.

- *Geographic Fee Adjustments.* Medicare's geographic adjustment factors (GAFs) are applied to Medicare payment localities that usually are based on MSAs. MSAs are typically based on county designations. This poses a problem for Mutual of Omaha for general claim payment on this basis because they do not have county designators on their provider database. They base indemnity reimbursement on provider zip code which cannot always be matched to a specific county. The inability to crosswalk provider location information prevents Mutual of Omaha from using Medicare GAFs or geographic practice cost indices (GPCIs).

4.4.1.3 Discussion

Mutual of Omaha is continuing to pursue adaptation of RBRVS into its products, particularly the managed care products. RBRVS-based payment provides a rational method of determining maximum allowances with a minimum of administrative expense. It can also facilitate price shopping/comparison for consumers. However, adaptation of the RBRVS is not spreading quickly across their entire product portfolio.

Balance billing protection is the major hindrance for indemnity product buyers. Mutual of Omaha's current indemnity products typically define maximum allowable charges in terms of "prevailing physician charges." If Mutual of Omaha decides to implement an RBRVS-based payment system for their indemnity products, they will have to first create and file new policy language and then seek approval from each state's insurance commission to use the new language.

Among the managed care networks, the major reasons for not adopting RBRVS include unfamiliarity with RBRVS, fear of physician rejection of RBRVS, contentment with current reimbursement methods, and/or lack of expertise to implement an RBRVS-based system. Some networks are waiting for direction from the federal government with respect to health care reform. Mutual of Omaha views capitation as a preferred method of physician reimbursement since RBRVS does not directly control utilization or intensity of services.

4.4.2 Payer 1[28]

4.4.2.1 Background

One of the leading indemnity insurers in 1992 (as measured by total revenue), is currently considering adoption of an RBRVS-based payment system for physician services. Payer 1 has a wide range of health insurance products, including indemnity and managed care products such as HMOs, PPOs and Point of Service (POS) products for their under and over 65 population. They have national geographic coverage, exemplified by their presence in the markets with more than 3 dozen cities. Approximately 40 percent of these cities are using some form of a relative value system for the managed care segment of their market. By the end of 1993, it is expected that half of those with an RVS system will use RBRVS as the basis. For the non-RBRVS segment of their market, Payer 1 uses a usual and prevailing (U&P) payment system. Essentially, reimbursement is based upon the physician's charges but in no case exceeds the U&P fee, which is usually set at 80 percent of all charges. The U&P system is often referred to as "unstandardized" and market driven.

4.4.2.2 RBRVS Implementation

Development

Payer 1 cited numerous benefits of an RBRVS approach, namely that the system will be maintained and updated by the federal government, thus reducing associated expenses. Other benefits cited include the Medicare fee schedule's national acceptance, its rational basis for payment, and its potential for cost control. Because the organization was changing to a new claims processing system anyway, the associated conversion costs of an RBRVS system were not a concern. The payer's main anxiety regarding this payment system is how to address the

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[28]This payer requested confidentiality.

issue of balance billing. The payer cited balance billing as the main reason why more payers have probably not moved to RBRVS.

Because individual payers do not have the legal authority to mandate balance billing provisions (for their indemnity products) as does Medicare, they continue to be perplexed by this issue. As a result, this payer, and many others, chose to adopt an RBRVS-based payment system for their managed care market only, and not for their indemnity products. Payer 1 plans, however, to eventually move RBRVS into the indemnity portion of its business. Specific decisions regarding this implementation are dependent upon numerous factors, especially the outcome of national health care reform efforts and the company's progress with implementation of RBRVS in their managed care market. The earliest date for RBRVS penetration into their indemnity business would be 1995. Payer 1 is considering negotiations with providers via numerous options for phase-in as a way of bringing physicians "on board." However, a phase-in process has not been used yet.

Payer 1 began implementing RBRVS into some of its managed care products approximately six months after publication of Medicare's RVUs in the *Federal Register* (November 25, 1991); and the remainder (up to 40% of their total) of its products were converted during the Spring and Summer of 1993.

Program Design

Payer 1 uses the 1993 Medicare RVUs as published in the *Federal Register*. They cited the possibility of supplementing these values with those produced by the Cambridge Health Economics Group (CHEG). They will not be making any modifications to the Medicare RVUs, and they intend to follow RVU updates outlined by Medicare. Implementation may or may not be budget neutral, depending on specific geographic location (city).

Relative Value Units and Conversion Factors

Although work is still in progress on the conversion factors (CFs) to be used, Payer 1 has chosen to use different conversion factors in the different geographic locations that it serve. Their process is best described as a fine-tuning of CFs by categories of service. In many cases, they simply "scale up" the Medicare CF by taking the fee Medicare would pay and multiplying it by a constant (i.e., 1.5), which results in their final fee. Beyond this process, each city can further adjust the fee specific to their locale. Procedures which would incur significant change may be exempt from this process and kept on the former subject to a phased-in movement to

the payment schedule. Geographic Practice Cost Indices (GPCIs) are used, yet a remapping process is under consideration.

Payment Policy Components

In general, regions have a substantial amount of autonomy with respect to payment policies, however, Payer 1 recommends that Medicare's patterns be adhered to. Below is a discussion of recommendations made by Payer 1, though local modifications can be made.

- *Global Surgery Policy.* Although specifics (i.e., pre/post days) may vary by surgical procedure, the basic global surgical policy which was previously in place will remain for both RBRVS and non-RBRVS business.

- *Anesthesia Payment.* The current method uses base-values plus additional units based on time. Nothing further is added for the procedure's complexity.

- *Assistant at Surgery.* Surgical assistants receive 20 percent of the primary surgeon's approved amount of the global surgical service, as opposed to Medicare's 16 percent.

- *Non-physician Practitioners.* Para-professionals are paid based on procedure codes developed by Payer 1. Codes may be different than those used for physicians, resulting in lower net reimbursement.

Payer 1 does not utilize explicit site-of-service differentials, and does pay for EKG interpretations. There is separate reimbursement for supplies and services incident to physician services.

In most regions, local arrangements have already been made for payment of laboratory services. However, Payer 1 is investigating the incorporation of RVUs for those regions without such arrangements. No specific decisions have been made.

4.4.2.3 Discussion

The reasons behind Payer 1's adoption of an RBRVS-based payment mechanism- a rational payment system, uniformity, and cost-control - are similar to those that motivated Medicare to adopt RBRVS. Thus, they have followed Medicare's lead by adopting RVUs, Medicare's update schedule, and some of its payment policy components. However, some

critical differences remain between the two payers. Specifically, the level of autonomy given to regional payers, with respect to CF modification and payment policy components, clearly distinguishes Payer 1's approach from that of Medicare. Nonetheless, this commercial payer has made significant movement in the direction of a resource based relative value payment system and is continuing to move in that direction.

4.5 Preferred Provider Organizations

4.5.1 Payer 2[29]

4.5.1.1 Background

Payer 2, a Mid-West based insurer which has both PPO and HMO products, covers a total of approximately one half million insured lives. In their home state, they have a wholly owned PPO and HMO network. In 40 - 50 other locations, they lease PPO networks or have joint venture arrangements with other payers/providers. In late 1992, a team comprised of individuals from departments such as actuarial, claims, provider relations, marketing, and research and development (R & D), developed a report reviewing the possibility of RBRVS implementation at Payer 2. The initial report recommended adoption of an RVRBS based system for all of the payer's products, however, no action was taken based on this recommendation. The report was resurrected in Spring 1993, at which time, actual movement toward implementation began and recent federal and state regulations were added into the planning.

4.5.1.2 RBRVS Implementation

Development

Payer 2 has been using the HIAA and MDR system for physician payment. They plan to have their home state PPO be the first to switch to an RBRVS-based system. This change is scheduled to occur by the end of 1993. RBRVS will allow them to reorganize their priorities from specialty to primary care and stay competitive in the industry. Another key advantage cited was the ability to compare providers' performance among their networks. Yet, Payer 2 is concerned about physician retention rates and the associated costs of enhancing their management information systems. Furthermore, they anticipate encountering some resistance to moving away from the more traditional payment system.

Movement to RBRVS will most likely occur "one product line at a time." Their implementation process begins with an analytic phase where their R & D department will collaborate closely with the payer's actuaries, assisting and training them with the intent of achieving the comfort level necessary to be able to work with new pricing protocols and a new

[29]This payer requested confidentiality.

computer system. Payer 2 was in the process of buying the fee schedule software developed by the Cambridge Health Economics Group (GHEG) at the time of this writing.

Next, they intend to implement the system on a manual or pilot basis, building information into provider files and creating system flexibility. They will complete the implementation process by performing a retrospective evaluation, perhaps including some impact studies, and make necessary changes. The retrospective evaluation will be done using MEDSTAT, a data base analysis system, and perhaps additional consultation from the Cambridge Health Economics Group.

Program Design

Payer 2 will use Medicare's RVUs and does not intend to deviate significantly from them. They have made a commitment to utilize RBRVS; it will be phased in on a site by site/network by network basis beginning in 1994.

Relative Value Units and Conversion Factors

Like Medicare, Payer 2 will use two conversion factors -- one for surgical and one for other medical procedures. They will be using Medicare's RVUs, but anticipate making modifications to existing RVUs in the areas of maternity and pediatrics.

Payment Policy Components

Payer 2 is still uncertain about which, if any, of Medicare's billing guidelines and payment policy components they will adopt along with RBRVS. However, they indicated that unlike Medicare, they will only use GPCIs if they feel there is a definite need to in order to stay competitive (Payer 2 has business in nearly all states, with the exception of New England). Providers are, and will continue to be, prohibited from balance billing patients.

4.5.1.3 Discussion

In general, Payer 2 is only at the commencement of their movement to a resource based payment mechanism. Numerous decisions remain to be made regarding the specifics of adoption. Yet, the activities which have occurred to date, and their progress toward implementing RBRVS payment policies, mirrors that of other payers like themselves.

4.5.2 Payer 3[30]

4.5.2.1 Background

Payer 3 is a PPO based in the Northwest region of the country. Their network of approximately seven thousand physicians and seventy hospitals is a multi-payor PPO that is leased by Mutual of Omaha, Metropolitan Life, Principal Mutual and the Travelers, to name a few. Payer 3 began implementation of an RBRVS-based payment system on March 1, 1993 and are currently implementing some of the associated payment rules. Payer 3 offers one Point of Service (POS) network and a PPO. The company also owns (insures and markets) an HMO as well as Medicare and Medicaid risk products. A small portion of their business is comprised of Medicare Risk products and Medicaid capitated arrangements. There are approximately three hundred thousand insured lives in their PPO and POS plans and about twenty-two thousand enrollees in their HMO. Payer 3 expects this number to increase to about forty-two thousand in the near future. Their former payment system was based on McGraw-Hill RVPs (Relative Values for Physicians). Prior to that, fees were based on the 1974 California Relative Value Scale (CRVS).

4.5.2.2 RBRVS Implementation

Development

The impetus for Payer 3 to move toward RBRVS was the large number of complaints received regarding their low fees (some fees were less than Medicare's) and the inability to use a single conversion factor for any given set of codes. Payer 3 felt that the California RVS and McGraw-Hill RVPs payment systems were inadequate because of the wide variation in fees across services. Additionally, many of Payer 3's competitors are adopting an RBRVS-based payment system.

Program Design

Payer 3 formed a Reimbursement Committee, comprised of the plan's Director of Operations (for both HMOs and PPOs), CEO, Director of Provider Services, medical director, underwriters, and others. This committee meets weekly to discuss issues regarding RBRVS

[30]This paper requested confidentiality.

implementation. One of the first decisions reached by the committee was for Payer 3 to go with a one-time implementation process as opposed to a phase-in approach.

RVUs and CFs

Payer 3 is using two conversion factors, one for medicine, radiology, and pathology and one for surgery. Eventually, they would like to converge to only one conversion factor. Payer 3 does not use Medicare's GPCIs, but they do maintain geographic variation by altering the conversion factor between East Washington state and the rest of the state. The conversion factors were developed by their underwriters using one year's worth of the plan's claims data. In order to update the conversion factors, they plan to follow in Medicare's footsteps. Final decisions will be made by the Reimbursement Committee.

Lab and radiology services were especially problematic. For now, Payer 3 will increase the radiology fee schedule, but they are aiming for a fixed fee schedule with only one conversion factor. Anesthesia services are paid on a discounted basis and not according to a fee schedule.

Payer 3 also has concerns about maternity and pediatric codes. When Payer 3 converted to RBRVS, most of the obstetricians in one of their rural counties threatened to leave the plan. These doctors have significant leverage with the plan because they are located in a rural area where demand for their services are greater that the available supply. Payer 3 had to make some concessions to keep these physicians. Overall, there has been no real significant physician "fall out" over the use of RBRVS.

Payment Policy Components

Providers in the Payer 3 network are contractually bound to the fee schedule. Payer 3 does not feel that balance billing is a concern since a maximum allowable fee schedule has been used in the past. Traditionally, the maximum allowable is applied to each CPT code and forwarded to the payer.

Although the RBRVS methodology has been incorporated into a fee schedule, physician payment policy components to accompany the fee schedule have not been fully developed. Payer 3 plans to solidify decisions regarding payment policies in Fall 1993. They would prefer to standardize rules to be consistent with Medicare rules. Ultimately, all decisions regarding their payment policies will be made by the Reimbursement Committee.

4.5.2.3 Discussion

Although Payer 3 had less than six month's experience with an implemented RBRVS fee schedule, they were well-versed in its technicalities. Both the organization and it's providers are pleased with the new system to date. Primary care physicians are quite satisfied with the implementation of RBRVS and there have been no real complaints from the specialists.

4.5.3 CAPP CARE

4.5.3.1 Background

CAPP CARE is not a direct payer of physician claims, yet it has a sizable impact on the payment methods used by a number of payers. CAPP CARE has 180 clients -- including insurers, third-party administrators, and self-insured companies -- which it advises regarding payment for health care services. The fees they recommend affect 70,000 physician members and over 3.1 million insured lives. All of these individuals are in some type of managed care arrangement. Many of CAPP CARE's clients have payment systems which are based on the California Relative Value Scale (CRVS). Beginning in March 1992, some of CAPP CARE's payers began adopting a system based on Medicare's RBRVS, and many others are moving quickly in that direction. The system they are implementing is not a "pure" RBRVS model, however, CAPP CARE is also preparing for adoption of a pure RBRVS system -- nearly identical to what Medicare has adopted. As of Fall 1993, CAPP CARE's "adopters" were one-third of the way toward complete implementation.

4.5.3.2 RBRVS Implementation

Development

Many of the factors behind Medicare's adoption of RBRVS are similar to those factors that motivated CAPP CARE. They view adoption of RBRVS as the wave of the future, especially for the managed care industry; and a necessary component of their cost-containment activities. And, they cite the difficulty in challenging its well-founded methodology.

Although CAPP CARE believes that the advantages of RBRVS outweigh the disadvantages, they were not completely free from concern. For instance, some of their clients are having difficulty switching over to RBRVS because of the changes required in their computerized billing systems. While these 'kinks' in the transfer process are being ironed out, some payers are simply placing the RBRVS amount into to a "maximum allowable" field of their software system until the new and old systems are completely synchronized. Another difficulty in the transition process is the change in the regional basis used for payment. Those payers who are using the Health Insurance Association of America's (HIAA) regional divisions, will have to convert to HCFA's Metropolitan Statistical Areas (MSA) as a basis for payment. Secondly, CAPP CARE noted that many staff members employed in physicians'

offices lack the sophistication needed to understand the complicated schedule and its billing rules.

Program Design

As a result of CAPP CARE's dissatisfaction with the self-inflating nature of the California Relative Value System, they are employing the following approach using HCFA's RBRVS -- a direct overlay of RBRVS onto the existing fee schedule and relative value units (RVUs). This was done on a phase-in basis.

Relative Value Units and Conversion Factors

The initial step of the overlay approach was to apply the Medicare Fee Schedule's unit values to the CPT codes that did not have established unit values (from the CRVS). The process concluded with an overlay of RBRVS onto CPT codes which already had established unit values. For those CPT codes without established RVUs from the CRVS, unit values were imputed using a multiple of the Medicare CF. At least 80 percent of the codes had unit values based on RBRVS, and the remaining 20 percent were assigned a code following adjustments made to align regions and areas with MSAs.[31] The overall impact was an increase in payment for cognitive services and a reduction in the payment of surgical services. CAPP CARE is using a single conversion factor to transform their unit values into actual fees. The conversion factor being used was selected specifically because it would result in comparable outlays to what CAPP CARE was currently spending (i.e., budget-neutral).

CAPP CARE views some areas of the Medicare RVUs as inadequate. For example, CAPP CARE imputed RVUs for pediatric codes because it felt Medicare's RVUs were not accurate. Some upward adjustments to RVUs were made in the areas of obstetrics, pediatrics, and anatomical pathology to more correctly reflect resources used for these services.[32]

Clients will have CAPP CARE reprice their fee schedule for January 1, 1994. This will be done by applying the contract amount to the physician claims, after incorporating any RVU changes to calculate the conversion factor and fee schedule.

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[31] Zalta, Ed. "RBRVS - Pay or Play." Managing Employee Health Benefits. Fall, 1993 (in press).

[32] Zalta, Ed. "Negotiating Payment Schedules: The Health Plan's Perspective." Presentation at the AMA conference RBRVS: Moving Beyond Medicare, May 21, 1993.

Payment Policy Components

With only two exceptions, CAPP CARE is adopting all of Medicare's billing guidelines. In fact, CAPP CARE had been using these guidelines since the early 1980s. The two payment policies they are not adopting are the new physician payment policy and non-payment of EKG interpretations. New providers will not be subject to lower reimbursement in comparison to established providers, and EKG interpretations will be covered. CAPP CARE is using Medicare's national lab schedule and the American Anesthesia Society's methodology for anesthesia services.

4.5.3.3 Discussion

The decisions made by CAPP CARE with respect to RBRVS will have a large impact on payment systems used in the private sector in the 36 states served by the CAPP CARE network. Its goal of implementing a pure RBRVS system is unique, in that most payers moving toward RBRVS are implementing a system which is based in part on the MFS methodology, but is identifiably different.

4.6 Case Study Synthesis

The primary objective of the case studies was to obtain technical, in-depth information about payers' fee schedule developments to complement the information from the Deloitte & Touche RBRVS survey. The protocols guiding the interviews varied by type of payer, but in general focused on (1) background of previous payment system, (2) barriers, perceptions and expectations of RBRVS, (3) technical development process of RBRVS fee schedule, and (4) payment policies and billing guidelines accompanying RBRVS fee schedules. A total of six public payers and six private payers were interviewed.

In addition to complementing the survey data with in-depth information, the case study findings support a number of trends and developments suggested by the survey data. Also, the case studies enable us to draw some key, preliminary conclusions regarding our research questions.

Exhibits 35, 36, 37, and 38 summarize the technical information and payment policies about public and private payers' fee schedules. General findings from the case studies indicate the following:

- Significant factors motivating payers to adopt RBRVS include: (1) desire to rationalize physician payments, (2) dissatisfaction with previous payment system, (3) avoid cost shifting, (4) maintain competitive fee levels and access to care, and (5) contain rising physician service expenditures.

- Closely related to motivating factors are payers' expectations and goals of RBRVS. A key expectation which varied across payers was on the cost containment potential of RBRVS. Some payers did not adopt RBRVS for cost control reasons (OWCP, Virginia Medicaid, Michigan Medicaid) while others maintain strong beliefs about the ability of RBRVS to control costs (CHAMPUS, WCF, Payer 1).

- RBRVS has been applied to managed care products, particularly PPOs. Payers stated that balance billing limitations were the fundamental reason for the lack of RBRVS adoption in indemnity plans. Another chief reason why RBRVS has not diffused more rapidly among all product lines is the lack of sophisticated computer systems and software among these payers.

- Although the RBRVS relativity concept is accepted by many payers, some modifications were made to "deficient" HCFA RVUs. These tended to be confined to obstetrical and pediatric service codes. Internal imputations using the payer's own claims data and/or adaptation of secondary data sources (e.g., McGraw-Hill RVS, CRVS, CHEG RVUs) were used to "fill the gaps."

- Multiple conversion factors were used widely as most payers used at least Medicare's surgical/medical categories. Private payers departed more from Medicare than public payers in terms of numbers of conversion factors. For example, Payer 1 and Payer 3 applied conversion factors on a geographic basis (Exhibit 37).

- Several payers will update RVUs along with Medicare (Washington and Virginia Medicaid, CHAMPUS, Payer 1, Payer 3, CAPP CARE), but formal update protocols for CFs have not been developed except for Washington Medicaid. Medicare's CF update procedure, the VPS, was unanimously rejected.

- In developing RBRVS fee schedules, most payers have gone forward with the technical developments of RBRVS fee schedules while neglecting payment policies and billing guidelines. Ironically, many payers do not have the technical expertise to internally maintain their fee schedules. In contrast, the three Medicaid programs (Washington, Virginia, and Michigan) and WCF have (or plan to) undertaken highly-formalized and structured approaches in developing the fee schedules and accompanying payment policy components. By forming and involving physician and non-physician provider advisory panels in the fee schedule development process, these payers have gained acceptance and approval from affected providers.

- Most payers used their own claims history to develop CFs, but many were not using a budget-neutral CF (See Exhibits 35 and 37).

- General adoption trends for Medicare's physician payment policies included: (1) Unanimous rejection of Medicare's new provider policy; (2) Nonpayment of EKG interpretations and the site of service differential policies being largely rejected; and (3) Surgical policies--global surgery, assistant at surgery, multiple surgery--generally being used by all types of payers. Payment policies for nonphysician providers varied widely among payers as many allowed different relative payments among providers vis-a-vis Medicare.

EXHIBIT 35
TECHNICAL ASPECTS OF PUBLIC PAYERS' FEE SCHEDULES

Technical Aspects of Payment Systems	Medicaid Departments			Workers' Compensation		
	Washington	Virginia	Michigan	West Virginia	OWCP	CHAMPUS
Conversion Factors ($)	maternity $43.97 pediatric $37.60 adult office $24.69 other $20.83	surgical(*) medical(*) approximately 96% x HCFA's	$19.4 - $24.8 sliding scale with "hold harmless" provisions	not derived	surgical(*) medical(*)	a
Budget-neutral CF	YES	YES	NO	undecided	YES	a
Volume Performance Standards	NO	NO	NO	NO	NO	a
HCFA RVUs Used	1993	1993	1991	1993	1993	a
MEDICARE RVU Modifications:						
OB/GYN/Maternity	c	undecided	YES (d)	undecided	NO	NO
Pediatric	YES (d)	*	YES (d)	undecided	NO	NO
Preventive	YES (d)	undecided	YES (d)	undecided	NO	NO
Team Conference	YES (d)	NO	NO	undecided	NO	NO
Telephone/After Hours	YES (d)	NO	NO	undecided	NO	NO
Update Guidelines						
RVUs	HCFA	HCFA	undecided	undecided	undecided	HCFA (f)
CFs	e	undecided	undecided	undecided	undecided	HCFA (f)
Implementation Date	Jan 1 1993	July 1 1994	Jan-92	July 1 1994	Jan 1 1994	*
Transition/Phase-in	undecided	3 years	one-time	undecided	one-time	gradual(b)

NOTES:

*** Not available.**

a CHAMPUS does not use CFs and RVUs directly (see text).

b CHAMPUS is converging toward Medicare fees via 15% annual reductions for overpriced procedures.

c Excluded from RBRVS fee schedule.

d RVUs were imputed.

e Legislative decision.

f After the transition is complete, CHAMPUS will update along with HCFA.

HCFA -- Payer uses HCFA's policy or approach.

EXHIBIT 36
PAYMENT POLICIES OF PUBLIC PAYERS' FEE SCHEDULES

	Medicaid Departments			Workers' Compensation		
Payment Policies	**Washington**	**Virginia**	**Michigan**	**West Virginia**	**OWCP**	**CHAMPUS**
Global Surgery	HCFA	similar	HCFA	HCFA	NO (a)	HCFA
Assistant at Surgery	similar	*	similar	differs	similar	similar
Multiple Surgery Payment	*	*	*	HCFA	*	HCFA
Geographic Adjustments	statewide GPCI	NO	statewide GPCI	NO	OWCP GPCIs	GPCIs
Nonphysician Providers	similar	differs	differs	*	similar	similar
Site of Service Differentials	NO	NO	*	*	NO	*
Nonpayment of EKG Interpretations	NO	NO	HCFA	NO	NO	NO
Laboratory Services (using Medicare's Nat'l Lab Fees)	differs	*	differs	*	HCFA	*
New Provider Reduction	NO	*	NO	NO	NO	NO
Balance Billing Limitations	YES (c)	YES (c)	YES (c)	NO	NO	HCFA

NOTES:

*** Not available.**

a Policy now being considered.

b CHAMPUS is converging toward Medicare fees via 15% annual reductions for overpriced procedures.

c Prohibited.

HCFA -- Payer uses HCFA's policy or approach.

Differs -- Payer's policy/approach differs significantly from HCFA's.

Similar -- Payer's policy/approach is different from HCFA's in minor ways.

EXHIBIT 37
TECHNICAL ASPECTS OF PRIVATE PAYERS' FEE SCHEDULES.

	Commercial Payers			PPOs		
Technical Aspects of Payment Systems	**Mutual of Omaha: Networks**					**CAPP**
	Seattle	**Portland**	**Payer 1**	**Payer 2**	**Payer 3**	**CARE**
Conversion Factors ($)	surgical(*) medical(*)	surgical(*) medical(*) radiology(*)	a	surgical(*) medical(*)	surgical(*) medical(*) obstetric(*) a	b
Budget-neutral CF	*	*	a	*	*	YES
Volume Performance Standards	NO	NO	NO	undecided	*	*
HCFA RVUs Used	1993	1992	1993	1993	1993	1993
MEDICARE RVU Modifications:						
OB/GYN/Maternity	*	YES	NO	YES	*	YES
Pediatric	*	*	NO	YES	*	YES
Preventive	*	*	NO	undecided	*	*
Team Conference	*	*	NO	undecided	*	NO
Telephone/After Hours	*	*	NO	undecided	*	NO
Update Guidlines						
RVUs	undecided	undecided	HCFA	undecided	HCFA	HCFA
CFs	annual	annual	undecided	undecided	undecided	undecided
Implementation Date	Spring 1993	Spring 1994	1993	Jan 1 1994	Mar 1 1993	Mar-92
Transition/Phase-in	one-time	one-time	c	pilot basis	one-time	d

NOTES:

*** Not available.**

a Varies by geographic location.

b Determined using a blend between pre-RBRVS and RBRVS fees and unit values.

c Varies by product line.

d Varies by payer client.

EXHIBIT 38
PAYMENT POLICIES OF PRIVATE PAYERS' FEE SCHEDULES.

	Commercial Payers			PPOs		
	Mutual of Omaha: Networks					CAPP
MEDICARE POLICIES	Seattle	Portland	Payer 1	Payer 2	Payer 3	CARE
Global Surgery	*	*	similar	undecided	*	HCFA
Assistant at Surgery	similar	similar	similar	undecided	*	HCFA
Multiple Surgery Payment	similar	similar	*	undecided	*	HCFA
Geographic Adjustments	NO	GPCIs	GPCIs	undecided	YES (a)	GPCIs
Nonphysician Providers	NO	NO	similar	undecided	*	HCFA
Site of Service Differentials	NO	NO	NO	undecided	*	HCFA
Nonpayment of EKG Interpretations	NO	NO	NO	undecided	*	NO
Laboratory Services (using Medicare's Nat'l Lab Fees)	differs	differs	differs	undecided	*	HCFA
New Provider Reduction	NO	NO	NO	undecided	NO	NO
Balance Billing Limitations	YES (b)	YES (b)	NO	YES (b)	YES (b)	*

NOTES:

*** Not available.**

a Payer uses a different approach from HCFA.

b Prohibited within the network.

HCFA -- Payer uses HCFA's policy or approach; Similar -- Minor changes from HCFA; Differs -- Significant differences from HCFA's

5.0 CONCLUSION

RBRVS-based payment systems have moved beyond Medicare and into other public and private sectors. Many payers view RBRVS as a viable, and in some cases a very necessary, option. Medicare began using its fee schedule based on RBRVS in January 1992 and is phasing it in over five years. Although some payers initiated research or development prior to 1992, most did not implement their system until this past year. This recent implementation has left many important decisions unmade, which will eventually need to be addressed. Despite the fact that many payers are still "in-process", there is much to be learned about RBRVS implementation to date.

While it is evident that RBRVS is being used by non-Medicare payers, what are the reasons behind these payers' interest in RBRVS and what gain do they expect from it? In general, other payers share Medicare's interest in supporting high quality, cost-effective health care services for their beneficiaries. One of the three primary goals of OBRA-89, the genesis of the MFS, was to create an equitable payment system for physician services. Our survey and case study results show parallel interests for other public and private payers. They desire a rational system based on sound methodology; one which is not inherently inflationary or difficult to update. Payers that are adopting RBRVS believe these are definite benefits of the system.

Many payers expect cost-containment to occur from adopting RBRVS. This may be attributed to the false perception that RBRVS and the MFS are synonymous. The MFS is a payment system based on relative value units which also includes an array of payment policies and volume performance standards (VPS) to update CFs. These three components comprise the new "system" which Medicare has adopted. The RBRVS, therefore, is only one part of the MFS. The RBRVS is a scale of relative values which comes from estimating the amount of resources (physician work, practice expense, malpractice expense) a physician typically requires to provide a service in comparison to the amount of resources required for other services (Hsiao, *et al.*, 1992).

The RBRVS provides a more rational system for payment of physician services vis-a-vis historical charge-based systems, but it was not meant *per se* to reduce or control total expenditures for services. The VPS is intended to constrain the *growth* in physician expenditures through the conversion factor update mechanism. Balance billing limitations were also adopted to protect beneficiaries from additional out-of-pocket payments. Private

payers that adopt RBRVS, but not Medicare's CF, VPS, or balance billing restrictions, may not achieve the cost-control that Medicare intends to with its more global approach.

A summary of the major findings for the key research questions is provided below.

- *What are the overall trends in the adoption of RBRVS?*

Overall trends can be found in terms of product lines, region and organizational size. RBRVS penetration is highest in managed care products. More than three-fourths of the products to which payers are applying RBRVS are managed care products. There was very little penetration into indemnity products as a result of potential balance billing. The diffusion of RBRVS is greatest for payers in the Midwest or West. States such as California, Washington, Minnesota and Wisconsin are known for their reliance on managed health care. Thus, the trends in adoption of RBRVS by region and product line appear to be correlated. Adopters of RBRVS also tend to be larger payers with respect to number of enrollees and total expenditures for physician services.

- *How do the trends vary by type of payer?*

RBRVS implementation varies tremendously by type of payer. BC/BS, IPA-model HMOs and PPOs are the payers in the study most likely to adopt RBRVS. Only a small percentage of indemnity insurers are adopting RBRVS. A primary concern of indemnity insurers with RBRVS is how to address the balance billing issue. Without provider contracts limiting balance billing, their beneficiaries may be exposed to additional charges from physicians. Decisions regarding this issue should be addressed by any payer applying RBRVS to its indemnity products.

Fifteen state Medicaid programs have implemented a system based on RBRVS; and another 11 are currently considering it. RBRVS is also being implemented in some state worker's compensation programs. There is growing interest by different payers in the public sector, such as Medicaid and worker's compensation, to band together and develop a state-wide system based on the RBRVS. This has been done in Washington and is currently under development in West Virginia. Finally, CHAMPUS, the national military health care system, is using RBRVS as a type of fee screen, where charges greater than the fully phased-in MFS amount are considered "overpriced," and is converging toward Medicare's fees.

- *What are payers' goals, expectations, and perceptions regarding RBRVS?*

Payers adopting RBRVS are more likely to perceive the commonly cited benefits of RBRVS to be highly important. They are particularly attracted to its ability to rationalize physician payment and move them away from a system that relies on historical charges. Non-adopters agree with their perspective but to a lesser extent. Many payers, both those adopting and not adopting, expect RBRVS to control costs. Medicaid programs, along with PPOs, see the system's ability to reward primary care physicians, through a reallocation of payment across specialties, as its most attractive feature. Rewarding primary care physicians is one way of securing access to care by insuring that providers are willing to participate in the Medicaid program.

Virtually none of the adopters view the drawbacks of RBRVS as highly important. Their greatest concerns are the potential negative impact on relationships with their physicians. They anticipate that physicians whose fees are reduced may leave their network. However, most adopters we spoke with at length have not had this experience. Certain adopters are also concerned about the costs associated with converting and maintaining systems based on RBRVS. Payers not using RBRVS are significantly more likely to view the commonly cited drawbacks as important. It appears that considerations such as the "newness" of the system and expertise it requires are factors that do influence their decisions.

- *How were payers' fee schedules developed?*

In developing RBRVS fee schedules, payers have generally gone forward with the technical aspects first, leaving payment policies, billing guidelines, and update protocols to be decided upon later. This trend is evident in both the D&T survey sample and our case studies. Specifically, Exhibit 12 shows that, on average, one-third of all payers adopting RBRVS are uncertain about adopting the seven Medicare payment policies in the survey. The extent of uncertainty regarding payment policies does vary by payer type as indemnity insurers had the most uncertainty while Blue Cross/Blue Shield plans had the least. The case studies revealed some uncertainty for individual payment policies while update methodologies for RVUs and CFs were found to be undecided upon or undeveloped by many payers.

The overall RBRVS fee schedule development process was highly formalized and structured for several public payers in our case studies. These payers involved physicians and other health care providers in the development process by establishing advisory panels.

Private payers, on the other hand, tended to use internal research departments and outside consultants to develop their fee schedule.

- *What particular modifications to HCFA RVUs and payment policies were made?*

The basic underlying concept of RBRVS--relative value rankings of physician services--is widely accepted by both private and public payers as being sound. However, many payers found specific types of services to be inappropriately valued vis-a-vis other services. Often, payers' concerns centered on relative values for services considered important in terms of service volume or for achieving specific program objectives. Such modifications include imputations and arbitrary adjustments to the RVUs. The D&T survey shows that one-third of all payers modified RVUs in at least one of the following areas of medicine: pediatrics, OB/GYN, pathology, radiology, surgery, emergency medicine, neurology, and rehabilitation. Another third of the D&T sample was uncertain about modifying Medicare RVUs. The Blue Cross/Blue Shield plans, for example, modified OB/GYN RVUs most often among these areas while managed care organizations modified OB/GYN and pediatric RVUs most often. State Medicaid programs reported modifying several areas with OB/GYN and pediatrics being the most prevalent. The case studies generally support these tendencies. For instance, Washington and Michigan Medicaid imputed RVUs for pediatric services and preventive services, but Virginia Medicaid is undecided. Washington Medicaid did not use Medicare OB/GYN RVUs at all while Michigan Medicaid modified them. Three of the six private payers in our case studies are modifying OB/GYN RVUs and two are modifying pediatric RVUs. Information from private payers in our case studies on modifications to RVUs for other areas of medicine was very limited--most were either uncertain about these changes or could not easily obtain the information.

The D&T survey results indicate tremendous uncertainty with respect to adoption of Medicare payment policy parameters. Overall, and by payer type, surgical policies--global surgery and assistant at surgery--were most often adopted while Medicare's EKG interpretation payment policy and volume performance standards were most often rejected. Adoption of budget neutrality, site of service differentials, and Medicare's anesthesia payment system varied by payer type. The case studies show similar findings. Among both public and private payers: (1) update protocols for RVUs and CFs, if decided upon, are consistent with HCFA's, (2) balance billing by providers within networks is restricted, (3) site of service

differentials have not been adopted, and (4) Medicare's new provider policy and VPS were unanimously rejected.

Several payers were using modified versions of some Medicare payment policies. For example, seven case study payers paid the assistant at surgery 20 percent of the primary surgeon's fee rather than 16 percent used by Medicare. Two Medicaid programs applied HCFA Geographic Practice Cost Index values (GPCIs) at the state level rather than at the Medicare payment locality. The Federal Employees' Compensation (FEC) program currently uses its own geographic cost indices based on its own area-specific costs and some Medicare Part B expenditure data. Under an RBRVS fee schedule, however, FEC will apply Medicare's GPCIs. Payers 1 and 3 both make geographic adjustments to fees by simply adjusting the conversion factor by location. Mutual of Omaha's Portland network applies Medicare's GPCI for Portland for all services billed in its network. Nonphysician provider payment policies varied from Medicare's as some payers allowed different percentage payments to physician assistants, nurse midwives, nurse practitioners, and clinical nurse specialists. Finally, some public and private payers were setting payments for lab services as a multiple of the Medicare National Lab Fee Schedule amounts.

- *How are RBRVS and MFS elements being incorporated into payers' cost containment strategies?*

Nearly half of all survey respondents viewed cost containment as a significant benefit of RBRVS. Interestingly, Medicare's cost containment mechanism--Medicare Volume Performance Standards--was adopted by only five percent of survey respondents and no case study participants. Since RBRVS essentially preserves fee-for-service practice and is not designed as a cost containment methodology, and volume performance standards are rarely being used, the application of RBRVS as a cost containment device is being done indirectly. That is, payers hoping to control physician expenditures under RBRVS believe that this system will limit "cost shifting" by other payers and will provide a standard for evaluating provider behavior more easily. Survey results indicate that more than 40 percent of adopters viewed RBRVS as a way to limit or avoid cost shifting (Exhibit 4). Some payers with large provider networks see RBRVS as an important management tool for evaluating the volume and intensity of physician services, and subsequently controlling the growth in costs.

The potential for RBRVS to be used for broader physician payment reform is significant, as evidenced by the adoption rates found in this study. The underlying relative value

principles of RBRVS are widely accepted among private and public payers. Widespread use of the other two major components of the MFS--Medicare Volume Performance Standards (MVPS) and payment policies--seems remote, however. In developing RBRVS fee schedules, payers have generally gone forward with the technical aspects first, leaving payment policies, billing guidelines, and update protocols to be decided upon later. This is, perhaps, a reflection of the great uncertainty by payers to adopt Medicare policies or modify their existing ones because of distinct differences in beneficiary population and program characteristics, the newness of RBRVS, and uncertainty over the outcome of national health care reform. Many payers now adopting RBRVS expect it to control their physician service costs, but through means other than MVPS. The distinction between the MFS and RBRVS is not clear for all payers and reflects the perception by many that RBRVS is intrinsically a cost containment methodology. For payers that do understand the difference between the MFS and RBRVS, the goal of cost containment is being pursued through indirect means such as limiting cost-shifting from other payers and improving information on physician behavior to limit increases in utilization and intensity of services.

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APPENDIX A

Representativeness of the Survey

Survey Database

The database used as a framework for compiling the Deloitte & Touche database was purchased from Charles J. Singer & Company. The organization conducts market research and provides systems information for private payers in the health care arena. Deloitte & Touche purchased five of their payer databases, merged them together, then added self-insured corporations and state Medicaid programs. They five databases purchased include indemnity insurers; Blue Cross & Blue Shield plans; third-party administrators; preferred provider organizations; health maintenance organizations; and independent physicians associations (IPAs). The IPAs provide administrative services to IPA-model HMOs, essentially acting as fiscal intermediaries.

Singer & Co. developed their databases through a multi-step process over a number of years. Annually, they collect updated lists of organizations from respective associations in addition to doing their own compilations of the published literature on plans. The number of payers in the Singer collection is close to the universe of payers in some categories. For example, the indemnity insurer database includes nearly all indemnity insurers in the US, whereas the TPA database is much less comprehensive.

Original and Follow-up Survey Comparisons

In an effort to determine the representativeness of the RBRVS survey, Deloitte & Touche conducted a follow-up survey of non-respondents. Information collected from a random sample of non-respondents stratified by payer type was used as a comparison for measuring selection bias in the original survey. The three groups contacted during the follow-up survey were indemnity insurers, PPOs, and state Medicaid departments. The non-respondents were asked the identical question as were the original respondents about the extent to which their organization has embraced an RBRVS-based payment system in addition to a handful of related questions.

The proportion of non-respondents adopting RBRVS was compared to the proportion of original survey respondents adopting RBRVS. This comparison was done separately in each payer area as well as overall . As shown in Exhibit A-1, the overall percent of adopters [1] in the

[1] An "adopter" is defined as any payer which is developing, undergoing implementation of, or has already implemented an RBRVS-based payment system.

original survey is less than one percentage point different than percent of adopters in the follow-up survey (33.6 versus 34.4 percent).[2]

Exhibits A-1 and A-2 also show the percent of adopters within payer types. There was a slightly greater difference (eight percent) in the percent of adopters between the original and follow-up groups of indemnity insurers, and a four percent difference in the PPO groups. The percent of state Medicaid programs in the non-respondent survey adopting RBRVS is twice as high as the percent of adopters in the original survey, indicating that the results from the original sample of state Medicaid programs are likely to be an underestimate of the true diffusion in the Medicaid sector. This finding was accurate. Through our follow-up efforts, we obtained from (nearly) the universe of state Medicaid programs regarding their implementation status, and were able to determine the true percent of RBRVS diffusion in this sector (See Section 3.2.1). In addition, we examined the differences in the ratios of the two samples in terms of those respondents who are *adopting* or *considering adoption* of RBRVS. In this case, the difference was slightly higher (9 percent) [3] (See Exhibit A-3).

Finally, we performed other comparisons between the two samples to determine if there were any substantial differences in their underlying characteristics. As shown in Exhibit A-4, there are only slight differences in the proportion of adopters within each region in the follow-up and original surveys. In terms of organizational size, the two populations do not differ significantly with respect to number of physicians or enrollees, but the respondents in the follow-up survey tended to have higher 1992 expenditures. [4]

Sample Size Calculations

The research team also calculated stratum specific sample size requirements which would be necessary to provide results that are within the true, unknown national average, assuming a normal distribution, with a 90 and 95 percent likelihood. The sample size calculations were retrospectively determined using proportions of respondents who adopted RBRVS-based payment systems. Table A-5 shows that the sample sizes in the original survey used were significant at the .05 level for third party administrators and IPA-model HMOs; and at the 90 percent level for PPOs and state Medicaid programs (combined sample). The sample size used for indemnity insurers was close to, but not quite equivalent to the 90 percent confidence intervals limit. These calculations provide additional confidence regarding the representativeness of the original sample.

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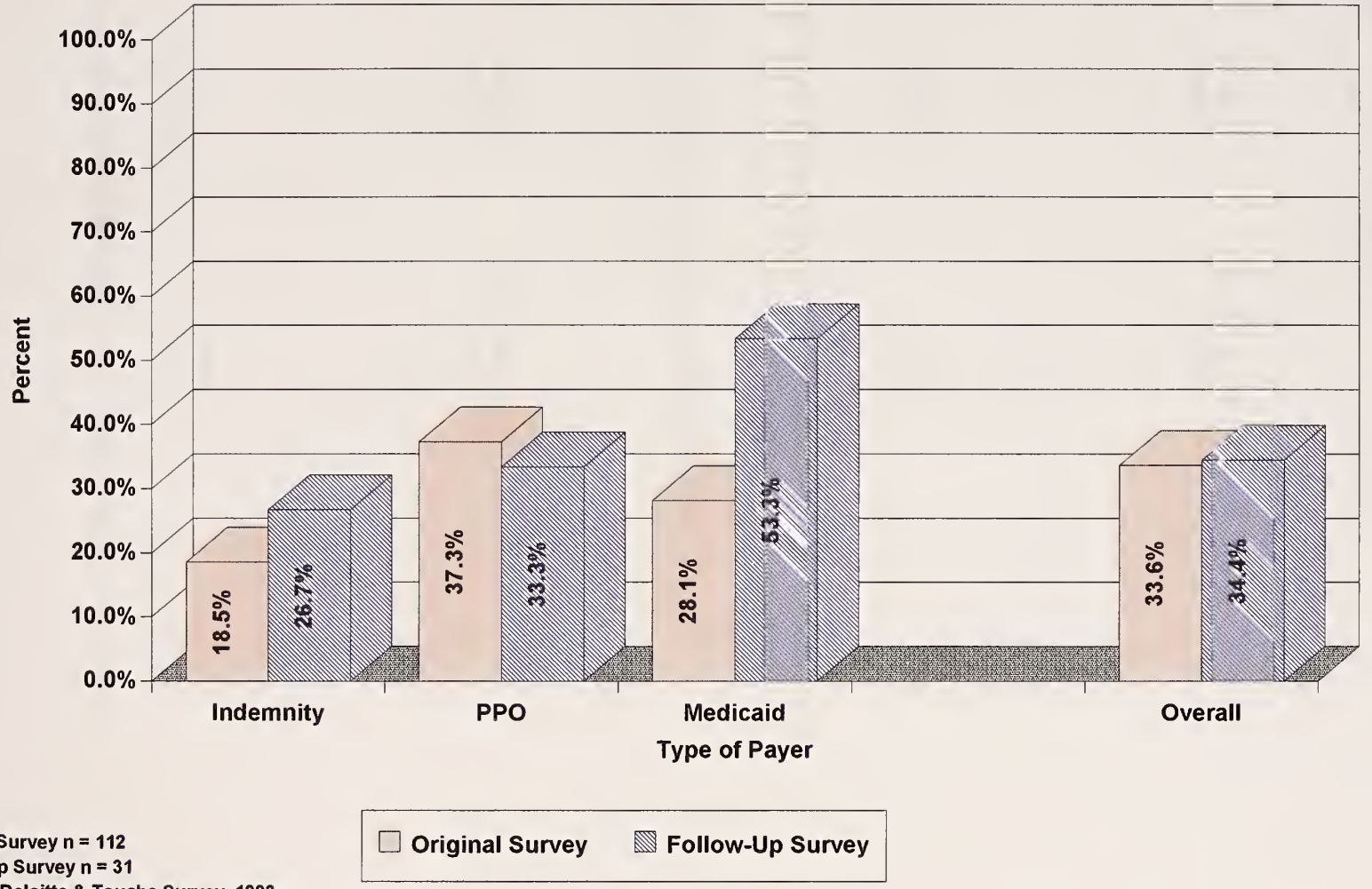
[2] This difference was not statistically significant (Chi-sq = .75; p = .386).
[3] This difference was not statistically significant (Chi-sq = 2.5; p = .113)
[4] T = 1.2, df = (58,89) for # physicians; t = .39, df = (74, 89) for enrollees; and t = 2.4, df = (27, 66) for payments.

EXHIBIT A-1
PERCENT OF PAYERS ADOPTING RBRVS BY PAYER TYPE: ORIGINAL AND FOLLOW-UP SURVEY



Original Survey n = 112
Follow-up Survey n = 31
Source: Deloitte & Touche Survey, 1993.

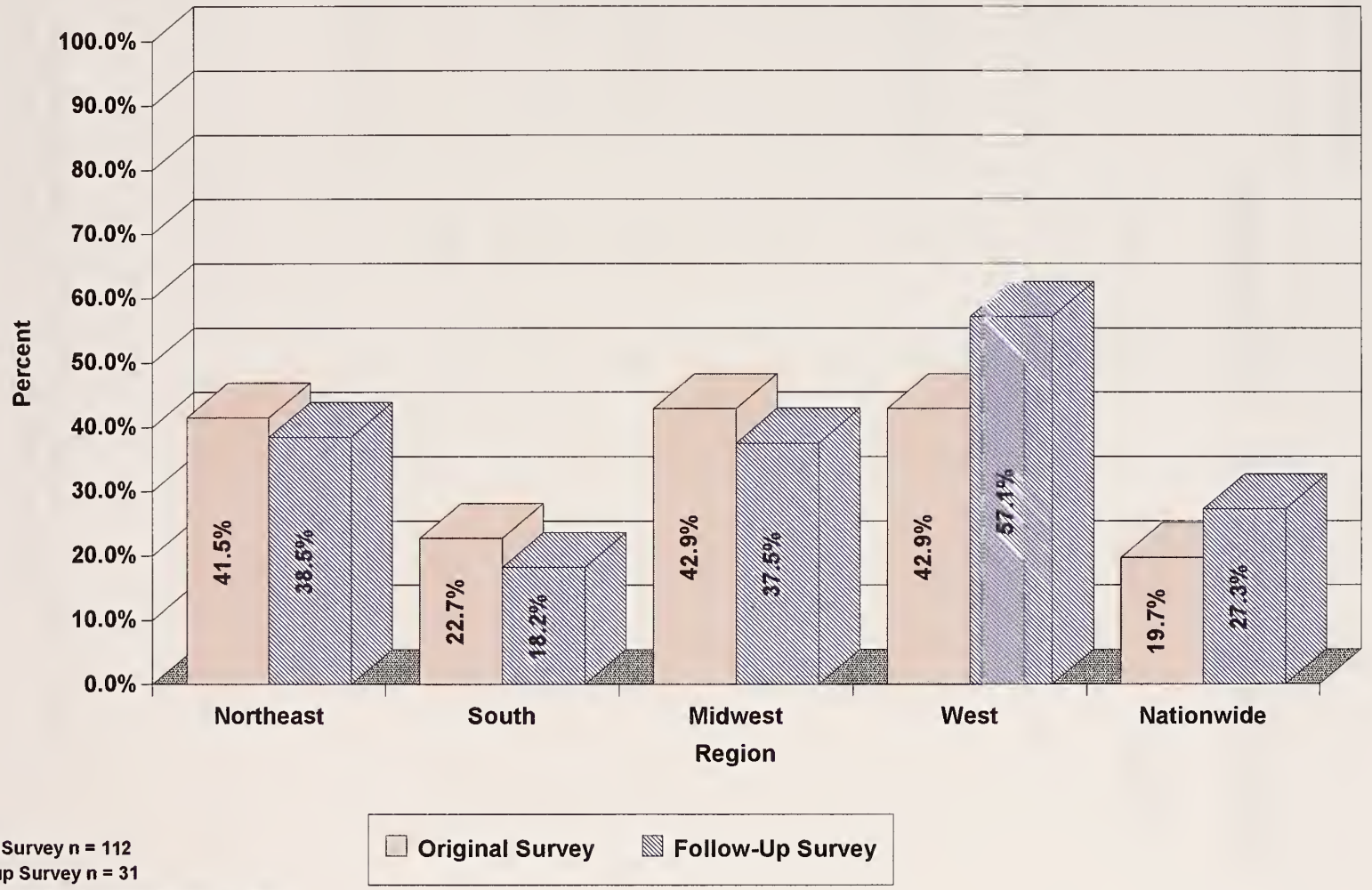
EXHIBIT A-2
PERCENT OF PAYERS ADOPTING RBRVS:
ORIGINAL VERSUS FOLLOW-UP SURVEY

Payer Type	Original Sample	Nonrespondent Sample
Indemnity	18.5 %	26.7 %
PPO	37.3	33.3
Medicaid	28.1	53.3
OVERALL	33.6	34.4
n	(112/333)	(31/90)

EXHIBIT A-3
PERCENT OF PAYERS ADOPTING AND CONSIDERING RBRVS:
ORIGINAL VERSUS FOLLOW-UP SURVEY

Payer Type	Original Sample	Nonrespondent Sample
Indemnity	77.8 %	70.0 %
PPO	74.5	57.8
Medicaid	56.3	73.3
OVERALL	73	64.4
n	(243/333)	(58/90)

EXHIBIT A-4
PERCENT OF PAYERS ADOPTING RBRVS BY REGION: ORIGINAL AND FOLLOW-UP SURVEY



Original Survey n = 112
Follow-up Survey n = 31
Source: Deloitte & Touche Survey, 1993.

EXHIBIT A-5
SAMPLE SIZE CALCULATIONS

	Confidence Interval		Actual Number of Respondents		
Payer Type	95%	90%	Original Survey	Follow-Up Survey	
State Medicaid Programs	50	38	32	15	= 47 *
Indemnity Insurers	40	29	27	30 *	
Blue Cross/Blue Shield Organizations	44	31	24		
HMOs					
IPA Models	67	47	87 **		
Staff/Group Models	43	30	10		
Preferred Provider Organizations	62	44	51 *	45 *	
Third Party Administrators	34	24	68 **		
Subtotal	340	243	299 **	90	
Self-Insured Corporations and Other (a)			34		
Total			333		

Key: p = .05 **
p = .10 *

Note: Sample sizes were retrospectively determined based on proportions of adopters in each payer category (assuming a sampling allowance of 10%).

(a) No self-insured corporations were adopting RBRVS.

DELOITTE & TOUCHE
SURVEY OF PHYSICIAN PAYMENT METHODS

April, 1993

OVERVIEW

Medicare's implementation of a new Resource Based Re'-tive Value Scale (RBRVS)-based payment system for physician services in January, 1992 represented the most significant physician payment reform since the program took effect in the mid-1960s. This action by Medicare has prompted many other payors to consider adopting similar approaches.

This initial survey has been developed to collect information on early trends related to the adoption of RBRVS. In it, we have focused on a key question facing all health care payors, whether to adopt all or part of an RBRVS-based payment system for their business.

This is the first of a new series of surveys which will track emerging trends in the adoption of RBRVS-based systems as well as identify changes that are occurring in physician payment policies and practices. We plan to use the data and our resulting conclusions as part of an overall research and publication effort by Deloitte & Touche, an international accounting and consulting firm, and the Cambridge Health Economics Group, a firm specializing in RBRVS issues.

Survey responses will be considered confidential. All participants will receive a copy of the summarized results and conclusions.

Completion of the attached questionnaire should not take longer than 15 minutes. Please compete all of the survey questions by June 1, 1993 and return in the enclosed envelope or by FAX to:

R. Thomas Swem
Partner
Deloitte & Touche
125 Summer Street
Boston, MA 02110
FAX#: (617) 261-8641

Questions regarding survey participation should be directed to Thomas Swem at (617) 261-8632. In advance, thank you for your participation.

I. General Information

1. Please indicate the name and address of your organization:

_____

2. Please indicate your present position:

_____

3. Please identify the division of your organization that is primarily responsible for determining physician payment policy:

_____

4. What type of payor organization are you primarily (Check one)?

____ Indemnity Insurer	____ Medicaid Agency
____ HMO - IPA Model	____ Blue Cross/Blue Shield Plan
____ HMO - Staff Model	____ Workers Compensation Plan
____ PPO	____ CHAMPUS
____ Third Party Administator (TPA)	____ Self-Insured Employer
	____ Other: _____

4a. What type of product lines does your organization offer (Check all that apply)?

____ Traditional Indemnity Plan	____ HMO
____ Managed Indemnity Plan	____ PPO
____ Medicare (non-HMO)	____ Point of Service
____ Medicare Plan (HMO)	____ Other: _____

4b. Approximately how many physicians is your organization paying?

_____

4c. Approximately how many enrollees are covered by your plan(s)?

_____

4d. What is your geographic coverage area?

_____

5. What were your organization's total payments for physician services in 1992?

_____

5a. How do these expenditures compare to previous years?

____ Much Higher ____ Slightly Higher ____ No Change

____ Much Lower ____ Slightly Lower

6. Does your organization use a fee schedule to determine payment levels for any physician services?

____ Yes ____ No

6a. If no, how are physician payments primarily determined (Check one)?

____ Salary ____ Other: _____

____ Capitation _____

IF NO, SKIP TO QUESTION 11

7. What percentage of physician services are reimbursed through a fee schedule?

_____ %

8. Which physicians are reimbursed through a fee schedule (Check all that apply)?

_____ All Physicians

_____ Selected physician specialties (Anesthesiologists, Pediatricians, etc.) (Please List): _____

_____

_____

_____ Physicians serving patients covered by certain payors types (Indemnity plans, PPOs, etc.) (Please List): _____

_____

_____

_____ Other: _____

_____

_____

9. Describe your fee schedule (Check one):

_____ Fixed payment per physician by specialty

_____ Usual and customary fee screen

_____ Other: _____

10. Has your organization made use of outside sources of information to establish or evaluate your physician fee schedule?

____ Yes ____ No

10a. If yes, please indicate which source(s):

____ McGraw-Hill's Relative Values for Physicians (RVP)

____ MEDINDEX's Medical Data Resources (MDR)

____ Health Insurance Association of America (HIAA) data

____ Other: _____

_____

II. Perceptions of RBRVS

11. Please indicate the importance level of each of the following **benefits** of RBRVS-based payment approaches as they are perceived by the management of your organization (Circle one per line):

Importance			
High	Moderate	Low	
1	2	3	Control health care costs
1	2	3	Rationalize physician payments
1	2	3	Make system compatible with Medicare's
1	2	3	Avoid cost shifting
1	2	3	Respond to competition
1	2	3	Reward primary care physicians
1	2	3	Other: _____

12. Please indicate the importance level of each of the following **drawbacks** of RBRVS-based payment approaches as they are perceived by the management of your organization (Circle one per line):

Importance			
High	Moderate	Low	
1	2	3	Disagree with RBRVS methodology
1	2	3	Concern with disrupting physician relations
1	2	3	Conversion costs too high
1	2	3	Believe current system is better
1	2	3	RBRVS too new — lack of track record
1	2	3	RVRVS is to complicated
1	2	3	Lack sufficient expertise to implement RBRVS
1	2	3	Other: _____

III. Extent to Which RBRVS Has Been Adopted By the Organization

13. To what extent has your organization embraced a RBRVS-based payment system?

____ Under consideration	____ Implemented
____ Under development	____ Decided not to adopt RBRVS
____ Undergoing implementation	____ Have not considered RBRVS

This is the end of the survey for organizations that have decided not to adopt RBRVS. Thank you for your participation.

14. To which of your organization's product lines does/will an RBRVS-based system apply?

____ Traditional Indemnity Plan	____ HMO
____ Managed Indemnity Plan	____ PPO
____ Point of Service	____ Other: _____

14a. What percentage of physicians that you pay will be/are subject to an RBRVS-type payment system?

_____

14b. What percentage of insureds will be/are receiving their care under an RBRVS-type payment system?

_____

15. Has/Is your organization planning to modify any of the Medicare Relative Value Units?

____ Yes ____ No ____ Uncertain

15a. If yes, please indicate the approximate number modified/to be modified:

_____

15b. If yes, in which of the following areas of medicine (Check all that apply)?

____ Pediatrics	____ OB/Gyn	____ Pathology
____ Radiology	____ Surgery	____ Emergency Medicine
____ Neurology	____ Rehabilitation	____ Other: _____

16. Has/Will your organization adopt any of the following payment policy components of the current Medicare Fee Schedule (Check one column per line)?

Adopted	Not Adopted	Uncertain	
____	____	____	Surgical service definitions (i.e., global packages now used by Medicare)
____	____	____	Anesthesia payment system
____	____	____	Nonpayment of EKG interpretations
____	____	____	Site of service (i.e., office vs. hospital outpatient) payment differences
____	____	____	Payment method for assistance at surgery
____	____	____	Volume performance standards
____	____	____	Budget neutrality (vis a vis existing payment levels)

16a. Was/Will the implementation of the Medicare Fee Schedule payment policy components selected above be immediate or phased-in (Check one)?

____ Immediate (Please specify effective date): _____

____ Phased-in (Please specify effective phase-in period): _____

____ Uncertain

17. Was/Will the implementation of the RBRVS-based fee schedule be immediate or phased-in (Check one)?

____ Immediate (Please specify effective date): _____

____ Phased-in (Please specify effective phase-in period): _____

____ Uncertain

18. How was/will your RBRVS conversion factor(s) be determined?

____ Budget Neutrality (Where total physician payments would not change)

____ Use Medicare Conversion Factor(s)

____ Other (Please describe): _____

_____

_____

19. Is/Will your organization use multiple conversion factors?

____ Yes ____ No ____ Uncertain

19a. If yes, what is the basis of the multiple conversion factors?

____ Geography ____ Specialty

____ Area of Medicine ____ Other (Please specify):_____

20. Do/Will you use the American Society of Anesthesiologists Relative Values (ASRVS), which pay services on anesthesia time spent?

____ Yes ____ No ____ Uncertain

20a. The Federal Government is considering establishing payments per anesthesia service regardless of time spent. Would you adopt such a system in place of a relative value scale approach?

____ Yes ____ No ____ Uncertain

21. Are/Will copays or deductibles be charged with RBRVS-based fees?

____ Yes ____ No ____ Uncertain

22. Have/Will any Medicare Fee Schedule-like changes be made in the way your organization pays for the services of non-physician health professionals?

____ Yes ____ No ____ Uncertain

22a. If yes, which non-physician providers are affected (Check all that apply)?

____ Physician's Assistants ____ Nurse Practitioners

____ Clinical Social Workers ____ CRNAs

____ Other (Please specify): _____

23. Please indicate the anticipated effects of an RBRVS-based payment approach on each of the following areas (Circle one per line):

	Positive	Neutral	Negative
Overall Organizational Impact	1	2	3
Utilization	1	2	3
Quality of Care	1	2	3
Equity of Provider Payments	1	2	3
Cost Control	1	2	3

24. How do you control the utilization of physician services (Check all that apply)?

____ Claims review by in house clinical staff

____ Claims review by in house non-clinical staff

____ Claims review by outside service

____ Claims review by unbundling software (HPR, GMIS, etc.)

____ Claims review by other software (Neural networks, Data Base comparisons, etc.)

____ Other _____

25. May we contact you by telephone to discuss your answers futher?

____ Yes ____ No

Name: _____

Phone: _____

END OF SURVEY. THANK YOU FOR YOUR PARTICIPATION.